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ABSTRACT

Presented are selected proceedings from the Conference on Supervision of Speech and Hearing Programs in the Schools (Bloomington, Indiana, June 15-26, 1970), attended by state and local school supervisors of speech, language and hearing programs and by university personnel with a special interest in supervision. Purpose of the conference was to emphasize the need for supervision of such programs, to examine the role and responsibilities of supervisory personnel in the schools, and to consider the kind of training which might best prepare them for such a role. Papers discuss the role of the clinician in exploiting the potential of public school therapy, leadership behavior and group effectiveness, procedures for counting and charting a target phoneme, the clinical process and qualities which characterize a good clinician, human relationships in supervision, federal support for speech and hearing, and program planning and evaluation to achieve accountability. Also included are the text of a panel discussion on the training of supervisors and consensus statements resulting from small group discussions on five topics related to rationale for, role, and characteristics of the supervisor. (KW)

Conference on

# SUPERVISION of Speech and Hearing Programs in the SCHOOLS

Speech and Hearing Center

June 15-26 1970

Indiana University Bloomington

Conference on

# SUPERVISION OF SPEECH AND HEARING PROGRAMS IN THE SCHOOLS

Speech and Hearing Center
Indiana University
Bloomington, Indiana
June 15-26, 1970

Jean L. Anderson, Ed.D.
Conference Director and Editor

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TABLE OF CONTENTS

Conference on Supervision of Speech and Hearing Programs in the Schools

Speech and Hearing Center
INDIANA UNIVERSITY
June 15-26, 1970

Monday, June 15

"It is recommended that, because of the fruitfulness of this conference, efforts should be continued to investigate the important issues identified here and to encourage interest in the area of supervision of speech and hearing in the schools."[1]

9:00-9:30 Registration and Coffee

9:30-10:00 Opening Remarks--Dr. Jean L. Anderson, Indiana University, Conference Director

Welcome--Dr. Kennon H. Shank, Director, Speech and Hearing Center, Indiana University

10:00-11:30 P.S. 1970 - How to Exploit the Potential--Dr. Frederic Darley, Consultant in Speech Pathology, Mayo Clinic, Rochester, Minnesota

* * *

1:00-1:45
2:00-2:45
3:00-3:45 Group Discussions - Rooms 73, 157, 18

Topic I - What are the benefits to a speech and hearing program resulting from the employment of a supervisor? (Can we develop a rationale to support the employment of a supervisor?)

Topic II - What constitutes the job of supervisor in the schools? (Can we develop a job description?)

Topic III - What are the characteristics we look for in a supervisee? (Can we develop a profile of the ideal clinician for the schools--knowledge, skills, personal factors?)

7:30 Social Activity

[1]This and other quotations are taken from the Summary and Recommendations section of the Proceedings of an Institute on Supervision of Speech and Hearing Programs in the Public Schools, held at Indiana University in June 1966, for clinicians, supervisors and university personnel in the State of Indiana.

Tuesday, June 16

"Although the supervisor of speech and hearing may function both as an administrator and supervisor, he is chiefly a leader of professional personnel and, as such, must be responsible for the development of common philosophies and beliefs about the therapy program and its goals."

9:00-12:00 The Role of Leadership--Dr. Joseph Reitz, School of Business, Indiana University

* * *

"The supervisor of speech and hearing must function within the administrative structure of the school system in which he is employed. (Speech and hearing clinicians in the schools must be participants in the total educational program and this philosophy should be reflected in the way the supervisor performs his duties.)"

1:30-2:30 Innovation In the Schools of the Future--Dr. John J. Horvat, Assistant Dean for Administration, School of Education, Indiana University

2:30-4:00 Group Discussion--The Leadership Role of the Supervisor in Innovative Programming for Speech and Hearing (Sharing ideas about needs and methods of implementation of new programming--THINK BIG!)

Group A-Room 73--Leader-Mr. Frederic Wolf, Rockland County (New York) Speech and Hearing Center
Recorder-Mrs. Linda Ramsey, Alachua County (Florida) Schools

Group B-Room 157--Leader-Mr. Robert Wedl, Minnesota Department of Education
Recorder-Miss Betty Mouk, Cincinnati (Ohio) Schools

Group C-Room 18--Leader-Mrs. Kathleen Pendergast, Seattle (Washington) Schools
Recorder-Mrs. Barbara Murray, Council Bluffs (Iowa) Schools

4:00-4:30 Leaders and Recorders meet to draft statement.

Wednesday, June 17

"Supervision requires a) the effective use of techniques and b) sound principles of management. Supervisors are responsible for the overall program but the decision-making process, involving both staff and supervisor, becomes the primary means of accomplishing the various goals of the program."

9:00-11:30 Setting Objectives and Problem Solving--Dr. John F. Mee, Dean of the Division of General and Technical Studies and Mead Johnson Professor of Management, School of Business, Indiana University

* * *

2:00-3:30 Group Discussion--Effective Relationships With School Administrators
(On applications for this Conference and on a questionnaire sent to supervisors in programs throughout the country a very frequently mentioned concern was that of communication with school administrators about the objectives and operation of speech and hearing programs. This session will be devoted to exchanging ideas and formulating methods of relating to educators at local, state and national levels.)

Group A-Room 73--Leader-Mr. Stan Dublinske, Iowa Department of Education
Recorder-Miss Nancy Chambers, San Antonio (Texas) Schools

Group B-Room 157--Leader-Mr. Donald Keeney, Merced (California) Schools
Recorder-Miss Carol Thomas, Muskegon (Michigan) Schools

Group C-Room 18--Leader-Mr. Tom Costello, Westmoreland County (Pennsylvania) Schools
Recorder-Miss Frances Johnson, University of Illinois

3:30 Leaders and Recorders meet to draft statement.

* * *

Evening Session - Poplars Room--Poplars Hotel

8:00-10:00 Supervision of Student Teaching--Problems and Solutions
Leader-Mr. Glenn Smith, Coordinator, Speech and Hearing, Orange County, California, Department of Education

Thursday, June 18

"The therapy process is a multi-dimensional process from the viewpoint of technical skill, behavior modification, the interpersonal process and the differences of those individuals who come to the clinician. It is apparent, then, that one 'method' is not sufficient to do 'good' therapy."

8:30-10:00 The Clinical Process - A Rationale--Dr. William Diedrich, Professor of Speech Pathology, University of Kansas Medical Center

10:30-12:00 Functional Analysis--Dr. Diedrich

* * *

1:30-3:00 Recording and Charting Therapy Progress--Dr. Diedrich

3:30-5:00 Supervision Procedures--Dr. Diedrich

* * *

5:30-7:30 Social Hour--Raintree Room--Poplars Hotel

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Friday, June 19

8:30-10:00 Multi-dimensional Scoring System--Dr. William Diedrich

10:30-12:00 Scoring Therapy--Dr. Diedrich

* * *

1:30-4:30 Scoring Therapy--Dr. Diedrich

Monday, June 22

"The supervisor must be able to apply certain techniques of group leadership, should have the ability to impart his skills and techniques to others, and should have a genuine interest in the welfare of others."

9:30-12:00 Group Dynamics in Supervision--Dr. Ronald Sommers, Director, Speech and Hearing Center, Temple University

* * *

1:30-3:00 Practical Aspects of Group Dynamics in Supervision--Dr. Sommers

3:30-4:30 Group Work Sessions

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Tuesday, June 23

"It is recommended that research be initiated to investigate the supervisory process as it relates to speech and hearing therapy."

9:00-11:30 A Close Look at the Clinical Process--Dr. Daniel Boone, Director, Speech and Hearing Center, Denver University

* * *

1:00-2:30 Demonstration and Practice in Analyzing the Clinical Process--Dr. Boone

3:00 Group Work Sessions

* * *

Evening Session - Room 18, Speech and Hearing Center

8:00-10:00 Supervision of the Paraprofessional--Leader--Dr. Richard Ham, Director, Speech and Hearing Clinic, Ohio University

Wednesday, June 24

9:00-10:00 Federal Support for Speech and Hearing - Now and the Future--Miss Mary Ann Clark, Educational Specialist, Bureau of Education for the Handicapped

10:00-12:00 Group Work Session--work on finalizing statements from previous group discussions

* * *

"It is recommended that the speech and hearing training programs investigate the types of training required for supervision of speech and hearing and initiate programs to prepare supervisory personnel."

1:30-3:00 Panel Discussion--Training of Supervisors of Speech and Hearing Programs in the Schools

Moderator--Dr. Kennon Shank, Director, Speech and Hearing Center, Indiana University

Miss Mary Wood, Speech and Hearing Clinic, University of Texas
Dr. Theodore Peters, Department of Communicative Disorders, University of Wisconsin
Mrs. Bette Spriestersbach, Speech and Hearing Center, University of Iowa

3:00-3:30 Group Formulation of a Consensus Statement on Training of Supervisors

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Thursday, June 25

9:30-12:00 Human Relationships in Supervision--Dr. Norman Kagan, Professor, Department of Counseling, Personnel Services and Educational Psychology, Michigan State University

* * *

1:30-3:30 Human Relationships in Supervision (continued)--Dr. Kagan

* * *

5:30 Social Hour and Dinner--Holiday Inn

Friday, June 26

"It is recommended that professional organizations interested in the speech and hearing impaired and professional educational organizations inter-relate at both state and national levels to resolve some of the problems which seem to exist in providing speech and hearing services in the schools."

9:00-10:00 ASHA's Perspective on Supervision of Speech and Hearing Programs in the Schools--Miss Thelma Albritton, Associate Secretary, American Speech and Hearing Association

10:00-12:00 Presentation of group statements

12:00 Adjournment

## FOREWORD

In the years that speech pathology and audiology has existed as a profession much effort has been expended in the investigation of the etiology and treatment of communication problems and the training of personnel to deal with such problems. However, the techniques of supervision as they might be applied to the training of personnel or to the provision of services to the communicatively impaired have only recently come into focus as a topic for concern.

The lack of supervision is particularly acute in the schools where frequently we find large numbers of clinicians working without coordination of their activities or with direction from individuals whose training and experience has been in another area. In addition, those relatively few individuals who presently hold positions as supervisors have had little or no specific preparation for their responsibilities.

The Conference on Supervision of Speech and Hearing Programs in the Schools which is reported here was an effort to emphasize the need for supervision or coordination of speech, language and hearing programs in the schools, to direct attention to the role and responsibilities of those individuals now employed in supervisory positions in the schools and to investigate the kind of training which might prepare them for such positions.

The Conference was preceded by several other endeavors related to the topic of supervision. In the summer of 1966, a Special Study Institute on Supervision of Speech and Hearing Programs in the Public

Schools, sponsored by the Indiana Division of Special Education and planned by personnel from the public schools and from the four university training programs in the state, was held at Indiana University for school and university personnel within the state. This was followed in the summer of 1969 by a Special Study Institute on the Supervision of Student Teaching in Speech and Hearing, again planned by personnel from the Division of Special Education, the university programs and the schools, and held at Purdue University. Because of the interest that was evidenced by individuals from outside the state in these activities and their resulting publications it was obvious that the concerns about supervision in the schools and the need for study of the topic were not confined to the state of Indiana but were, indeed, a nation-wide concern.

Further proof of the significance of the topic of supervision at this time came from personnel of the Bureau of Education for the Handicapped of the U. S. Office of Education and the American Speech and Hearing Association. And, if more evidence had been needed, it came from the responses to the announcement of the Conference and to a questionnaire which was sent to supervisors throughout the country prior to the Conference. The mere fact of the great number of responses cannot begin to reflect the interest. The comments written on both applications and questionnaires revealed a concern for the status of speech and hearing programs in the schools and the need for supervision of such programs, an urgent desire to communicate with other supervisors, and sincere support for the Conference, even from those who could not attend.

Participants in the Conference were chosen from three groups--state and local school supervisors of speech, language and hearing programs, and university personnel who have a special interest in supervision. The program included contributions from speech pathology concerning the clinical process and from the areas of psychology, education, and business management, all of which have studied the supervisory process as it relates to their own field. In addition to the presentations of the invited speakers, presentations were made by certain members of the group. There were numerous opportunities for group discussion and, always, a generous sharing of information by all participants.

The proceedings of the entire two weeks cannot be presented in this publication. It is hoped that, from those portions which are presented here, some readers will gain new insights into the supervisory process as it applies to speech, language and hearing therapy; that some will become concerned about the need for employing supervisors in speech, language and hearing programs in the schools; that others will be alerted to the need for training supervisors who can assist clinicians in providing better services to children with communication problems; and that each reader will do whatever he can within his own situation to promote the training and employment of supervisors of speech, language and hearing programs in the schools.

Unfortunately, no publication could ever capture the interest and the cooperative spirit of the fine group of people who attended the Conference and contributed so greatly to its success.

P.S. 1970 - How to Exploit the Potential

Frederic L. Darley, Ph.D.

I believe we have at our disposal the ingredients of a very successful professional endeavor, the goal of which is a really significant contribution to the general welfare. The Preamble to our Constitution states that one reason why we organized the United States of America was to "provide for the general welfare." In our work we are implementing that.

It was not ever thus. In an earlier day aberrant communicative behavior was not viewed as something to be looked upon with compassion and treated; rather, it was viewed with suspicion, distrust, scorn, and fear. To illustrate the point, I would like to read a few paragraphs from the book Precious Bain by Mary Webb. The main character in this book is a girl named Prudence Sarn, who lives in the Shropshire country of England. She is in love with a man named Hester Woodseaves. The trouble is that Prudence has an unrepaired cleft of the lip. In this book we get a picture of what it meant in an earlier day to be such an obviously handicapped person.

Prudence, a country dweller, is visiting the town of Lullingford and she tells us about the reception she got at a tavern:

> "We went into the Mug of Cider for a snack. Ten or a dozen old men sat without. Each one was holding a great pewter tankard, and they were roaring out of the top of their voices. But when we were come by these old ancients, every one held his mug where it was, and stopped in his singing, and so sat with his mouth open and his eyes fast on me. There they sat, with the inn behind them and the frosty sunshine on their old, red veiny faces and a kind of frittened look. As we passed the bench, every head of them came around slow, and the score or so of eyes stared slantwise over the rims of their cups, as young owls will stare and turn their heads, watching you over their feathers.

"As we went through the dark doorway with its doors studded with nails like a prison, and came into the inn parlor, where sat the more genteel, I saw their looks fastened on me, too, but more shyly. All of them looked up, quiet and careful but very curious, at me. All on a sudden I knew that all these folk, the grand ones within and the old fellows without, were staring at my hare-shotten lip. They were thinking, according to their station and learning--

"'Here's a queer, outlandish creature!'

"'This is a woman out of a show, surely to goodness!'

"'Here be a wench turns into a hare by night.'

"'Her's a witch, an ugly, hare-shotten witch.'

"Maybe in the tuthree times I'd come to Lullingford in the past they'd stared so, but then I was but a child and didna see. . . .

"The folk inside looked at each other and I wished I could die. For all the bitter cold and my thin gown and us being far from the fire, I was all in a swelter. For indeed I loved my kind and would lief they had loved me, and I felt a friendliness for the drovers and the gentry, and the host and his missus. For they were part of my outing and part of Lullingford and of the world,. . . . I would lief have ridden forth and seen new folk, new roads, new hamlets, children playing on strange village greens, unknown to me as if they were fairies, come there I knew not whence nor how, singing their song and running away into the dusk; old folks wending their way along paths in meadows of which I know not so much as the name of the owner, to churches deep in trees with all the bells a-ringing,. . . . Ah, I should dearly ha' liked that. Only the gist of it must ever be that the old folk looked kind as they saw me go by, and the children smiled or threw me a blossom, and that when I came to inn or tavern they'd say, 'Draw into the fire now, dear 'eart, for night thickens.' Ah, I'd dearly ha' liked that!

"This made it all the more of a shocking thing to me that the real world was thus toward me, for living so apart I had not truly felt my grief afore. But now I knew that I was fast bound in misery and iron, as the Book saith. Ah, prisoned beyond a door to which the great nailed door of the inn was but paper!"

So, in an earlier day this sort of problem was viewed with suspicion and fear. It was not dealt with with compassion but with cruel misunderstanding.

I'd like to read another selection, this one from Samuel Butler's book, The Way of All Flesh. Published in 1903, this book punched the

last nails into the coffin of Victorianism with all of the rigidities and cruelties which that system implied, especially with regard to treatment by parents of children. It was a rigid and personal autocracy of parents over their children. The characters in this part of this autobiographical novel are four-year-old Ernest Pontifex; his father, the Reverend Theobald Pontifex; his mother, Christina Pontifex; and his brother, Joey. The events are related by the narrator, Overton:

> "I was there on a Sunday and observed the rigor with which the young people were taught to observe the Sabbath. One treat only was allowed them--on Sunday evenings they might choose their own hymns.
>
> "In the course of the evening they came into the drawing-room, and, as an especial treat, were to sing some of their hymns to me, instead of saying them, so that I might hear now nicely they sang. Ernest was to choose the first hymn, and he chose one about some people who were to come to the sunset tree. I am no botanist, and do not know what kind of tree a sunset tree is, but the words began, "Come, come, come; come to the sunset tree, for the day is past and gone." The tune was rather pretty and had taken Ernest's fancy, for he was unusually fond of music and had a sweet little child's voice which he liked using.
>
> He was however, very late in being able to sound a hard "c" or "k," and instead of saying "Come" he said "Tum, tum, tum."
>
> "'Ernest,' said Theobald, from the armchair in front of the fire, where he was sitting with his hands folded before him, 'don't you think it would be very nice if you were to say 'come' like other people, instead of 'tum'?'
>
> "'I do say tum,' replied Ernest, meaning that he had said "come.". . . .
>
> Theobald noticed the fact that he was being contradicted in a moment. He got up from his armchair and went to the piano.
>
> "'No, Ernest, you don't,' he said, 'you say nothing of the kind, you say 'tum' not 'come.' Now say 'come' after me as I do.'
>
> "'Tum,' said Ernest, at once; 'is that better?' I have no doubt he thought it was, but it was not.

> "'Now, Ernest, you are not taking pains: you are not trying as you ought to do. It is high time you learned to say 'come'; why Joey can say 'come,' can't you Joey?'
>
> "'Yeth, I can,' replied Joey, and he said something which was not far off 'come.'
>
> "'There, Ernest, you hear that? There's no difficulty about it, nor shadow of difficulty. Now, take your own time, think about it, and say 'come' after me.'
>
> "The boy remained silent a few seconds and then said 'tum' again.
>
> "I laughed, but Theobald turned to me impatiently and said, 'Please do not laugh, Overton; it will make the boy think it does not matter, and it matters a great deal;' then turning to Ernest he said, 'Now, Ernest, I will give you one more chance, and if you don't say 'come,' I shall know that you are self-willed and naughty.'
>
> "He looked very angry, and a shade came over Ernest's face, like that which comes upon the face of a puppy when it is being scolded without understanding why. The child saw well what was coming now, was frightened, and, of course, said 'tum' once more.
>
> "'Very well, Ernest,' said his father, catching him angrily by the shoulder. 'I have done my best to save you, but if you will have it so, you will,' and he lugged the little wretch, crying by anticipation, out of the room. A few minutes more and we could hear screams coming from the dining-room, across the hall which separated the drawing-room from the dining-room, and knew that poor Ernest was being beaten."

Today we view these differences differently, and we gird ourselves to reduce those differences that make a difference. The success of our effort, I think, depends upon skillful nurturing and blending of certain ingredients. What are they?

The first of them is love. I believe our people are characterized by an <u>other</u>-<u>orientation</u>; not an <u>inward</u>-orientation or a <u>self</u>-orientation but an <u>other</u>-<u>orientation</u>. And they view others with compassion. Our people are willing to sacrifice something of themselves. They try to seek out others and their problems rather than shun them. They try to

understand these problems rather than ridicule them. They sympathize rather than scorn, and they help rather than punish. This is characteristic of what has been called the therapeutic attitude.

In his new book The Crime of Punishment Karl Menninger talks about the therapeutic attitude: "All of the participants in this effort to bring about a favorable change in the patient, that is, in his vital balance and life program, are imbued with what we may call a therapeutic attitude. This is one of direct antithesis to attitudes of avoidance, ridicule, scorn, or punitiveness. Hostile feelings toward the subject, however justified by his unpleasant and even destructive behavior, are not in the curriculum of therapy or in the therapist."

Perhaps the current crop of clinicians, more than in earlier generations, has this kind of drive--that is to say, love as the motivator. I think our youth have moved away from what might be called a goal orientation such as to find a career, get a degree, get a job, get money in the bank, get security, get food and shelter, etc. Our society tries to provide a lot of this almost automatically. Since many of these things are guaranteed, our youth do not have their eyes set on them. They don't set their eyes on some distant future but they want--right now--to play a role and get involved. They are role-oriented and not distant-goal-oriented. And so it seems to me that, perhaps even more than in the past, they want to get involved; they want to find an identity through hooking up with other people. They find their self image and mold it through positive interaction with other people. They want to share their abilities. They want to share themselves. They are willing to risk themselves to experiment. They are willing to engage in a work that involves commitment.

The Apostle Paul said, "Love is not arrogant or rude. Love bears all things, believes all things, endures all things" and that is really what we're talking about. This is a very powerful ingredient in any endeavor. Love really changes our lives. It is dynamic. It seems to me that love is the first ingredient in what we do.

Now I left one thing out of Paul's list. He said, "Love hopes all things." And that is the second ingredient--hope.

Again let me quote from Dr. Menninger: "There is another element in the therapeutic attitude. It is the quality of hopefulness. If no one believes the patient can get well if no one, not even the doctor, has any hope, there probably won't be any recovery. Hope is just as important as love in the therapeutic attitude." It appears that Dr. Menninger is re-doing the Bible, going back to the basics that Paul talked about.

In our work we are convinced that behavior is capable of change, that children can do better if they are shown how. Parents usually aren't really malicious and they aren't really out to do harm. They are usually just poorly informed. But they are capable of learning and they can change and exert positive influences, not necessarily negative ones. And so we express our conviction about these things through an encouraging attitude. We are optimistic. We verbalize expectations of improvement and success in the work that we do and in our contacts with children and their parents.

Lest you have forgotten it, I would like to review for you a study that got at this, not in the case of children but in the case of adults with aphasia. Dr. Margaret Staicheff (1960), who conducted the study,

was interested in knowing whether one can change the performance of aphasic patients by the kinds of instructions one gives them. She divided a total of 42 patients into three groups, which were equated in their capacity to do some simple verbal tasks, naming pictures, or reading words. The first group of 14 patients was subjected to what we called the encouraging condition. The experimenter approached them with a smile and told them she was sure they were going to do just fine and, as she met them on three successive days, she would say, "My, I was pleased with how well it went yesterday. It was just splendid. I was pleased you did so well and I'm sure you can do even better today." She smiled a lot and during the 30-item task injected eight to ten positive comments like, "Yes, that's right" or "Good" or "It's coming better now."

A second group of 14 patients was subjected to what was called the discouraging condition. The same experimenter came at it differently. She was grim. She did not smile. She let them know that she was disappointed. She told them from day to day, "It was very hard for you yesterday. I'm surprised at how much trouble you had. I don't suppose it will be any easier today." During the task she injected eight to ten negative remarks like: "No" or "That's not right" or "It seems to be taking longer and longer, doesn't it?"

The third group was subjected to a neutral condition. They were neither praised nor blamed. They were not told whether they had succeeded or failed. They were just told each day, "We have more of the same things to do; let's do them."

How did the study come out? At the beginning the three groups performed similarly. But after three days of such exposure those in the encouraging condition performed significantly better than those in the discouraging condition, with those in the neutral condition falling in between, closer to the encouraging than to the discouraging. We also asked the patients how they thought they did. Those in the encouraging condition thought they did well, liked Dr. Staicheff a lot, and hated to see the experience come to an end. Those in the discouraging condition thought they did terribly. They disliked Dr. Staicheff and some of them just about didn't return for the final session. One spouse reported that her husband lay awake all night trying to decide whether to come back and see that woman again.

A significant point is that these were not brand new aphasic patients. The mean duration of their aphasia was 12½ months. They were exposed to these conditions for no more than about 30 minutes a day for three days. In this brief time it was possible to manipulate their behavior in the desired direction. I think the implications of the study are significant, and they are significant for every pedagogue everywhere. We change behavior best by an encouraging approach rather than a punitive one. The threat of failure constitutes a poor approach. The encouraging attitude, furnishing information about success, works.

The third ingredient: I think the clinical situation provides a model for growth. A therapy session can be a microcosm of--can represent in miniature--what goes on in the macrocosm of the world. We can do in the clinic things that will have great implications

outside the clinic and give a person a taste of what it might be like to behave like that outside. We can build, through therapy, happiness into the lives of people. We can build character. We can show the person we are working with that he isn't the only one who has a problem; everyone has a problem, and people learn to cope with their problems. We can demonstrate that the clinician, confronted sometimes by certain kinds of unfortunate behavior and strong feelings on the part of the patient, can handle those behaviors and feelings. He isn't done in by strong feelings directed at him nor by his own feelings. As he handles them, so can the patient.

The clinician can demonstrate the joy of doing a workman-like job. The clinician can demonstrate dependability. He can demonstrate faithfulness. He can demonstrate conscientiousness and thoroughness. He can demonstrate respect for other people and self discipline. The client can learn from all of this. Surely the actions of the clinician speak louder than all of his words.

Now as the fourth ingredient, we have the resource of technical skill which the clinician brings. He has some know-how regarding clinical procedures--what to do and how to do it. He has a grasp of what "normal" is; he has some understanding of the range of normal and some understanding of what constitutes an impairment and a handicap. He has developed a feel for reward as a technique and a vehicle for reinforcement of the behavior desired. He has developed a kind of sophistication as a listener. He can listen to the speech of youngsters and discern what's wrong. He can do another kind of listening, too: he can listen to what patients tell him, I mean he can <u>listen</u> and <u>hear</u> what is said and <u>interpret</u> it.

Now these skills are not fully developed. They require practice; they require sharpening up and honing down. A clinician has to find out the limits and the values of his procedures; what the power of a test is and its limitations. He needs to broaden his concept of normal. He needs ever more unerringly to perceive the motivations and the hangups of his patients. While he is doing that, he is learning more about his own motivations, biases, weaknesses, and hangups. Then, of course, there are always coming along new techniques, instruments, and procedures to which clinicians need to be introduced so that their armamentarium will keep enlarging. This requires continuing education which those in supervision can provide, and so we have workshops, short courses, long courses, and seminars.

Our goal in working with the clinicians in our school systems is not to help them take a set of technical skills brought from the university and somehow congeal these. Rather we must try to keep them fluid and growing and eternally improving. Our goal is not to making them like the character of Morrison in Joseph Conrad's novel Victory.

Victory is the story of Axel Heist and his love for Lena. He took Lena away from a very unhappy situation to a tropical island. In their days together he told her about his life and his good friend Morrison. Morrison was obsessed with the idea that the low-grade coal on the island of Samburan could be mined and shipped--somewhere. Surely there was somebody who would buy it. Morrison was going to make his fortune and Axel's fortune, and everybody's fortune. So he went off to Europe to undertake this grand endeavor--and he died.

Axel says of Morrison: "He was the sort of man to whom you can't explain anything. He was extremely sensitive, and it would have been a tigerish thing to do to mangle his delicate feelings by the sort of plain speaking that would have been necessary. His mind was like a white-walled, pure chamber, furnished with, say, six straw-bottomed chairs, and he was always placing and displacing them in various combinations. But they were always the same chairs. He was extremely easy to live with; but then he got hold of this coal idea--or, rather, the idea got hold of him. It entered into that scantily furnished chamber of which I have just spoken, and sat on all the chairs. There was no dislodging it!"

So, well taught by our professors, we emerge from training with a mind full of chairs. The trouble with Morrison, as Conrad points out, was that however he might place and displace or rearrange the chairs, they were always the same chairs. So, if we and those we supervise do nothing but shuffle the furniture about, we run out of combinations. We begin looking at what we are doing; we may get bored; and we get defensive. We need not, however, be stuck with this furniture and have to keep shuffling it around. We can organize ourselves completely differently. We are not confined to a static set of facts and techniques which we must keep nicely glued in place. We can put things together in new ways, recognize inconsistencies, discern gaps, ask searching questions. We can discard some of the furniture and acquire new furniture, get some new upholstery, perhaps acquire a whole new suite sometimes.

This particular ingredient is the clinician's ingenuity, his skill, and his ability to have all he knows shaped and kept fluid and growing and changing so that, unlike Morrison, he is not stuck with the same equipment everlastingly but can do new and more interesting things. We can help our growing clinicians upholster their chairs and reupholster them and ultimately get them a new suite.

The fifth ingredient is the opportunity of time. It is very nice that the schools have allotted us a quota of time in which to bring about some changes in certain youngsters. The question is whether we can schedule this time so that our impact is focused, not diffuse; so that our influence is enduring not transitory. It is reassuring that the mood within the public schools is in the direction of smaller caseloads, more individual work, longer sessions. For too long we have been plagued with a philosophy or at least a practice in speech correction analogous to the doctrine of homeopathy in medicine. The leader of the homeopathic medicine movement, a man named Hahnemann, died a millionaire in 1843. He led a school of thought about the use of drugs to elicit in the patient the illness which one was trying to prevent, actually a kind of forerunner of vaccination. But one of the curious features of this school was the theory of dosage: the effects of the drug become more powerful the smaller the dose that is given. This is the "theory of potency." "Small doses kindle vital capacities, moderate doses increase them, and the largest doses remove them." So since small doses kindle vital capacities, these practitioners believed in the infinite dilutability of their medication. This led to a lot of derision among doctors and it certainly must have led to bitter resentment

among druggists. For liquid drugs Hahnemann recommended the 30th potency, the 30th dilution, you might say. You do it this way: Take two drops of a liquid medication and dissolve it in 99 drops of alcohol. That is the first potency or the first dilution. Then take one drop of that and dilute it in 99 drops of alcohol. This is the second potency or the second dilution. Then take one drop of that, and dilute it in 99 drops of alcohol to make your third dilution. You repeat this until you get down to the 30th dilution or potency. That is the one you use because, you know, "small doses kindle vital capacities." One of the critics of that day said that the administration of a homeopathic medicine was like trying to put out a raging fire by "slyly injecting at one of its windows, once in every few minutes, a spoonful of water containing a globule (tenth dilution) of a solution of a grain of some suffocative chemical substance." Castiglioni in his History of Medicine says that one benefit that grew out of the school of homeopathic medicine was that physicians learned that diseases often did better when exposed to fewer remedies or to none. We agree that some speech deviations disappear when no remedy is applied, but of course we know this cannot be said of most speech handicaps with which we concern ourselves. Surely we must avoid the risk of being viewed as homeopaths in speech therapy, somehow believing in the efficiency of speech therapy infinitely diluted. Our effort should be to bring influence to bear on a child with such concentration, such intensity, such perseverance, that his habits will change and new behavior will become fixed in minimum time with minimum inconvenience.

Sixth, and last, and perhaps the most priceless ingredient of our potential in public school speech correction, is that the clinician possesses not only heart, not only a pocketful of skills, but also a mind. He thinks. He knows that the disordered behavior he has to deal with is complex behavior; it has multiple determinants. Some of these determinants are anatomic. Some of them are physiologic. Some are chemical, others anthropologic, sociologic or psychosocial, genetic, linguistic, psychiatric. He knows that to understand disordered communication requires a comprehensive view of the behavior of an individual in a family in a society with a culture which has a tradition. All of this requires a lot of knowledge, understanding, and wisdom.

Of course the clinician also has learned that although this behavior is complicated, it is lawful. It is understandable. It is analyzable. It is not inscrutable, not haphazard. It isn't just coincidental or accidental. It is not capricious. He knows he can measure things and find out how things got to be. Measurable causes underlie measurable observable phenomena. There is a unity in the whole world and certain laws underlie everything in the world. So the clinician has learned to look for orderliness, for causation. He looks for the variables that enter into this mix.

He has learned to ask a lot of questions. We help him to ask others: <u>What</u> questions, for one thing. What is the child doing? What can't the child do? What is Mom doing? What are they doing together? What's going on? And the clinician also asks a lot of <u>Why</u> questions. Why can he do this but not that? Why can't he produce that sound in these

words for me? After six years of therapy why is he still unable to carry it over into conversation? Is this articulation problem perhaps part of a more comprehensive problem, a language processing problem? The clinician extends his horizons in his conceptualization of the problem; he asks why questions concerning auditory discrimination, auditory reception, auditory memory, auditory sequencing, auditory fusion, and auditory closure. And the clinician asks why questions about the child's ability to program motor acts. Although the child can program simple ones, why can't he program sequences of them? Although he can produce a posture for a sound or a syllable, why can't he produce a sequence of postures? Does he display an apraxia of speech?

The clinician knows that although he must ask many why questions covering a wide area, in the end he must develop a working hypothesis. He must do something for this youngster and it must be focused. The principle of parsimony helps him trim down his multiple hypothesis to a single working hypothesis and focus his therapy in terms of it. Then he can critically test that hypothesis in therapy. That is what he is doing as he works, gathering data to support his hypothesis. Under what conditions can the child perform as desired? The clinician will manipulate the parameters and observe the effects. How does the child perform with amplification, with masking? How does he perform with visual monitoring of his performance? Does he perform differently without it? How does he perform with and without a visible model? How does he perform when he is required to slow his performance, when latency is forced upon him? How does he perform when we vary the

number of stimuli and the number of responses? Does he do better when we give him one stimulus and he makes one response, or when we give him one stimulus and he makes three responses, or when we give him three stimuli and he makes one response, or some other combination? Here we have an inquiring, searching, investigating clinician, not just parroting what he has been taught but going on from there.

We ask ourselves, "Where does new knowledge come from?" It may end in a book but it surely didn't start there. It started with some kind of question, some kind of itch that somebody scratched. I believe firmly that there is no dichotomy between clinical work and research. Research is not what Ph.D.'s do in the laboratory. Research is planned, systematic observation in a controlled situation with manipulation of relevant variables and objective recording of the result. And who can do that? Everyone can do that. We all can. The public school clinician can be helped to see that he is in a marvelous position to participate. The best reason why he can be an important participator in this quest is that he is where the action is. He is where the patients are. Emerson said, "We are as much gainers by finding a new property in the old world as by acquiring a new planet." We can't all be astronauts, but we can all serve mankind in our clinical-research day-to-day endeavors. We should, as supervisors, help others do this.

We see that we have priceless, indispensable, sure-fire ingredients for a successful professional endeavor in public school therapy. The outcome depends upon all of us doing our jobs well in training and in supervising. The supervisor may well be the catalyst who makes everything

happen and come out right. Dr. Theodore Mitau, head of the Minnesota State College System, recently said, "A society that treasures orderly change and acknowledges the urgent need to release the creative impulse can ill afford to leave teaching to the uninspired and ill-informed." The supervisor must supply some of the information and much of the inspiration and imbue the profession of public school speech therapy with a new sense of drive, of dignity, of pride, and of commitment.

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## Leadership and Group Effectiveness

H. Joseph Reitz, Ph.D.

I'd like to talk to you today about some of the things that we've been able to find out over the past 30 or 40 years of systematic social science research in the field of leadership--findings that apply to leadership in any kind of an organization. I'm not going to present you with a cookbook list on how to lead or ways to fool people or to get people to do everything you want them to do. You and I know that leadership is a much more complex activity than that, dependent on the situation and the nature of the people involved. My goal is to present you with some data and with some attitudes that, upon reflection over a period of a few weeks and an application to your own situation, you will find useful in operating in the kind of organization in which you work.

### Power, Authority, and Influence

Whenever we talk about leadership we think of several terms related to manipulation of people. For instance, we may think of a leader as one who exerts power, one who has authority, or one who uses influence. I always find it helpful in discussing leadership to clarify these concepts. I think there are distinctions to be made among power, authority, and influence. Influence, to me, means that state or the act of getting somebody to do something you want them to do. A leader influences his followers when he actually gets them to behave the way he wants them to. He causes them to conform to his wishes in one way

or another. Power, on the other hand, is the capacity to influence others. Authority is what I'd like to refer to as legitimate power, the capacity to influence people that comes from some legitimate source.

Let's take as an example that construction worker out by the barricades who prevented us all from parking where we wanted to this morning. Suppose I came speeding around that circle and he said, "Stop!" If I stop, he's exerted influence on me. If he puts up his hand and I go right through the barricade, he hasn't exerted influence on me at all. He may have the power to stop me with his barricades and he may have the authority. Did anyone question whether he had the authority to stop us or not? Nobody really did. We all presumed he had the authority to do it. Maybe he really didn't have the authority at all to do that. But he certainly had the power because he had those barricades and he looked rather tough. I even tried to walk around him, but he wouldn't let me do that, either, so he had power. He certainly exercised influence. We don't know whether he had authority or not.

The three concepts can really be distinguished in our own situations. We can think of times in which we may have exerted influence on people without having the authority to, but certainly it's difficult to think of influence being exerted without some kind of power.

## Leadership Defined

However, we still haven't quite come around to a definition of leadership. Therefore, what I'd like to do for about ten minutes is to have you work on your own by giving you the following task. I'd

like you to break up into groups, and I want each group to come up with some sort of consensus about the names of two people who were or who are <u>great</u> leaders. Take just about 10 minutes and do this.

Break

Let's see if we can get everybody to commit themselves now. Do we have a spokesman for this group? "We decided on Jefferson and Jesus." "We had Hitler and Ghandi." "We had consensus on Jesus and all but one agreed on Freud." "We had Jesus Christ and Julius Caesar." "We had Christ and Churchill." "We have Churchill, Martin Luther." "Martin Luther King, Ghandi." "John Kennedy, FDR." "Hitler and Brigham Young."

One way to define leadership is to look at those people who are considered to be great leaders and find their common characteristics or traits. Look at the list you have here. Do you see anything that all these people have in common? "They were all men." "They were all proud of something." "They were all persuasive speakers." "They all extended their influence over a period of time." Did they have any physical or personality characteristics in common? Well, it's difficult to think of any traits they had in common and there's good reason for it. In 50 years of research in what is known as the <u>trait theory</u> of leadership--that is, looking for traits which are characteristic of leaders of all kinds--we have failed to uncover one single personality trait or set of traits that distinguish leaders from non-leaders. We no longer believe that a leader can be identified by giving him a test or looking at him or measuring him or weighing him.

There's always been the question, "Are leaders born or made?" I think we can say, at least as far as research shows, that leaders have to be made because they are certainly not born that way. If you look at the people who become good leaders or great leaders, you find that usually their success couldn't have been predicted. So that gives us confidence that we are not wasting time in trying to train leaders. The fact is that leaders are made; leadership not only <u>can</u> be learned, it <u>has</u> to be learned. So what we're going to talk about is leadership as behavior and what we're <u>not</u> going to talk about is leadership as a person.

One of the central things I want to get across to you is that it is no longer useful to think of leadership as residing in a single person. We're going to talk about leadership as the process of directing and/or facilitating the activities of a group toward a goal. Working toward a goal is one of the philosophies we carry over from business management to other kinds of activities and organizations. We try to get away from being activities-oriented. We try to think as much as we can in terms of being goal-oriented. Effort, by itself, is not useful. It's not important how hard you try unless you know where you are going. That is why we consider leadership as a process of moving toward a goal. Leadership is not exercised only by the guy who's up there in front of the group saying "Charge" but also by somebody in the back who's pushing, or somebody who recognizes he's in the group's way and steps out of the way.

Leadership Behavior

Let me list some of the types of behavior that people engage in in groups or organizations. There are three categories of activities that individuals engage in when a group is working toward some goal.

First, there are task-oriented activities. One of these activities is initiating the work, getting people started on some task. Another task-oriented activity is information seeking. The group needs a variety of inputs, resources of all kinds. They need money and materials. They need people. They need ideas and they need information. But somebody in the group may be engaged in information seeking activities and that certainly has to be thought of as a task-oriented activity. Somebody else, of course, may be a resource person for the group. He becomes involved in giving information. Anytime you get more than three or four or five people together you always begin to develop some sort of a communication problem. So somebody may be involved in clarifying something for the group. Elaborating is a form of clarifying, but can be thought of as a separate task activity. Orienting is another one--trying to determine the group's position in relation to its goal. And, finally, coordinating. These are some of the activities which would fall under our definition of leadership. That is, they facilitate or direct the group toward some goal.

But a group not only must have some direction, it must have unity. Another set of activities which it is useful to specify are what we call group-building activities, activities that help the group stay together. We often think of following as apathetic behavior, and certainly there is a distinction between acceeding leadership in someone

else and actually withdrawing. Following is a group-building activity because the alternative to following is splintering off. So sometimes when people follow a leader they are helping the group. They are setting some sort of example to help build the group and maintain its cohesion. Another group-building activity is tension relieving. Sometimes in any group or organization it's helpful to have somebody who is so much of a tension reliever that he's classified as a clown. Because many organizations and many groups get into tense, competitive situations in which pressures build up, it is helpful to have someone who can break up the tension. Few recognize the value of such behavior; the clown can become the scapegoat of the group. But if he is removed from the group, its members may find that they aren't functioning as well because the tensions are not being released. Encouraging and harmonizing are also group-building activities, as is standard setting--establishing internal goals as well as external. Standard setting is a means of developing pride or cohesiveness in the group. The person who says, "We ought to try this in such a way, have this kind of quality in our output and these kinds of standards when we accomplish our goal" is setting standards for the group--helping the group develop some pride in itself, perhaps thereby attracting members to the group and building cohesion.

The third type of activities which people often engage in are called <u>self-serving activities</u>. These activities tend to detract from the facilitation or the direction of the group toward its goal. First of all, there is withdrawal, as exemplified by the person who says, "I

don't care what you do--I'm not going to play your game." He may withdraw physically or mentally. He may become very apathetic toward the group and that certainly is a self-serving activity. On the opposite pole of that is aggression--sniping at the leaders or other members of the group. Sometimes it is very difficult to deal with this kind of activity. It is useful to remember that aggressive behavior is usually a result of frustration. What makes it difficult to deal with is that we're usually dealing with a symptom of frustration, not with a cause. Certain kinds of behavior in the group are attention getting. We distinguish this type of activity from elaborating. A person who is elaborating is usually engaged in clarification or information-seeking activity. Attention getting is talking about something that's irrelevant to the group's activities but very relevant to the person who's trying to get the attention. Blocking activities are those which get in the way of other people's progress toward the goal or which impede the group as a whole. Dominating behavior includes all sorts of power plays or exercising influence for its own sake. All of these activities will go on in any group but they usually serve the self-interest of only one or a few members of the group.

Task-oriented and group-building activities facilitate the movement of the group toward the goal while self-serving activities detract from the goal. Sometimes, when working with a group, it is useful to recall these categories and to classify the activities of various group members

accordingly. In that way one can get an idea of the contributions of each member of the group and of the efficiency of the group itself by determining the ratio of task-oriented and group-building activities to total activities.

## Leadership Dimensions

A lot of research has been done differentiating between these two kinds of leadership activities--task-oriented and group-building activities. What some people have done is to study the process of leadership by examining these two different dimensions of leadership behavior, trying to relate them to the effectiveness of the group.

Let me give you an idea of what kinds of leadership activities are involved, as ascertained by questionnaires submitted to group members. Task-oriented activities of leadership are described in the following ways:

"He talks a lot about how much work ought to be done.
Slow working people are encouraged to greater efforts.
Overtime work is encouraged.
The appointed leader assigns people under him to particular tasks.
The leader often asks for sacrifices from the men for the good of the entire department.
There is insistence that people follow standard ways of doing things in every detail.
The leader sees to it that people are working up to their limits.
He insists that he be informed of decisions made by people under him.
He stresses being ahead of competing groups.
He decides in detail what shall be done and how it shall be done.
He emphasizes the meeting of deadlines.
He asks people under him who have slow groups to get more work out of the groups.
He emphasizes the quantity of work."

Group-oriented kinds of activities are described as:

"The leader expresses appreciation when one has done a good job.
He sometimes does personal favors for his people.
He helps them solve problems.
He does not criticize his people in front of others.
He does not refuse to give in when people disagree with him.

He does not reject suggestions for change.
He does not treat people under him without considering their feelings.
He does not always act without consulting his people first.
He backs up his people and their actions.
He treats his people as his equals.
He criticizes a specific act rather than a particular individual.
He is willing to make changes.
He's friendly and can be easily approached."

One way to analyze a leader is to ask his workers to describe how often he engages in each of the above activities. One can then place the leadership somewhere on the continuum from task-oriented to group-oriented. Some leaders may seldom engage in either type of activity. Such leadership is described as impoverished. Other leaders are high on one dimension and low on the other. A task-oriented leader may seldom engage in group-oriented activities. One who is high on group-oriented activities but who neglects task-oriented activities is known as the country club type--most of the activities are directed toward making people happy and pleasant and comfortable but not much attention is devoted to the task. Still other leaders may reach the middle of the road, where they engage in enough task activity to accomplish the goals and enough group-building activity to hold the organization together.

The interesting thing about the country club style is that usually it is based on an assumption by the leader that a happy worker is a productive worker; that satisfaction leads to productivity. But the research on productivity and satisfaction has indicated that, if they are related, it is not because satisfaction leads to productivity but the reverse of this--productivity leads to satisfaction. In laboratory experiments and field investigations in organizations it has been

found that the group which turns out to be the most productive is the one that has the leader who has the energy and ability to drive the group to accomplish the goal. They may not be the happiest--but, then again, they may. It has been shown that the relationship may be reversed. That is, people who are productive may tend to be happier because they get some intrinsic satisfaction out of the job that they are doing. You have all experienced that. You've worked hard on something and, although it was a tough job and you weren't very happy about it when you started, you did do a good job and you got some satisfaction from it. But the satisfaction didn't cause the productivity. It is very dangerous to assume that just because you make people happy they are going to be productive.

Another way of looking at leadership is by examining what's known as leadership style, taking a pattern of activities and behavior and trying to identify the leadership style that exists. This approach has looked at three different styles: authoritarian, democratic, and laissez faire. I want to talk about this briefly because there's a lot of controversy in the literature about <u>authoritarian</u> versus <u>democratic</u> styles and certainly there are a lot of people today who seem to be all in favor of <u>laissez faire</u> leadership. There have been some very interesting demonstrations which have examined the differences in these styles of leadership and their effects on group behavior. The <u>authoritarian</u> style of leadership usually consists of one person who is <u>the</u> leader who sets the goals or objectives for the group. He usually determines the composition of work groups. He determines what are going to be the means the group is going to use to attain its goals. He sets

the standards and evaluates performance. His standards for evaluation are subjective and his criticism is often personal in nature. He doesn't criticize the task itself, he usually criticizes the person. On the other hand, the democratic leadership style usually is one which involves the group on a continuum ranging from advising the leader to actually participating directly in decisions. The group itself takes a hand in setting the goals and determining work group composition and methods of attaining the goal. There may be some self-evaluation or peer evaluation involved. Standards are usually more objective, and criticism is toward a specific act, rather than an individual. Laissez faire describes a situation in which leadership, if any, is passive. One finds it very difficult to distinguish such a leader from the rest of the group. The leader may be working along with the workers. He may act as a resource for information, but he doesn't go out of his way to tell anybody what to do or how to do it.

From the identification of these three different styles of leadership a number of interesting research projects have developed, trying to establish the effects of leadership style on the behavior of the group. The findings have shown the following things: Members of authoritarian groups tend to exhibit more apathetic or aggressive behavior than democractic groups. They tend to be somewhat submissive. Democratically-led groups, on the other hand, seem to be more cohesive as a group. They tend to be more friendly toward the leader and toward each other. Their orientation toward the leader differs in that authoritarian-led groups spend a lot of time trying to get the leader's attention. As far as the laissez faire type of leadership goes, one finds some of the same

kinds of reactions here that we found in authoritarian--some apathy or outright hostility toward the leader or toward anyone who tries to exercise leadership. When one looks at the laissez faire type of leadership one finds that productivity is poor. The quantity and quality of groups led by the democratic style tend to be good. But there is also good quantity and quality in authoritarian groups.

In autocratically-led groups, because of a high dependency on the leader, the group frequently has problems when the leader is absent. Depending upon how long they've been conditioned to the autocratic leadership style, when the leader leaves them alone they stop, they don't know what to do, they sit around, they wait for someone to tell them what to do. In the democratically-led group, absence of the leader does not have as much effect because the members are already in motion, they know what some of the goals are and they've been engaged in some of the decision-making activity. They are not conditioned to waiting for somebody to tell them what to do. In the laissez faire group, absence of the leader makes no difference because he isn't doing anything anyway. The group will continue at the same low level of performance.

We might expect to see more differences in productivity of authoritarian and democratically-led groups than we do. But we cannot make the generalization that one leadership style is more effective than the other.

## Situational Leadership

It appears, then, that many of our approaches to leadership have been simplistic. We have said, "Let's just find great leaders and everyone will be happy." Well, we found out that we couldn't do that

so we said, "Let's find the best leadership style, apply that across the board and then we'll be happy." Unfortunately, that doesn't appear to be the solution either. So, where does that leave us?

The answer seems to be that leadership is much more complex than either the "great-man" theory or the great leadership style theory. It seems to me that the most effective kind of leadership theory today is what is known as the contingency theory or situational approach. This theory of leadership simply states that there are such things as more and less effective styles of leadership, but that these are not universally applicable across the board. The most effective style of leadership depends upon a certain number of things. It depends upon the leader, the membership of the group, and the nature of the task.

First of all, a leader has to know himself well enough to know the leadership style in which he is most comfortable and in which he is most convincing. There are those who can play the range all the way from an authoritarian to a democratic leadership style. Some, however, find it difficult because of their own personality makeup to be a democratic kind of a leader. If a person can recognize that when he tries to be a democratic leader he's not very convincing or that he just can't live with it, maybe he's better off not trying to operate in that manner. On the other hand, some people are not comfortable being authoritarian leaders and no matter how hard they try they simply cannot do a good job as an authoritarian.

Some individuals can combine the styles so that they operate differently in different situations. Some may be forced to change. For example, even the most democratic leader may have to become authoritarian

if he receives a directive from above. Or, a time factor may make it impossible for an otherwise participative leader to utilize the group's aid in making a decision.

One of the things that good leaders seem to be able to do is to meet the expectations which are held by the group for the leader. The good group leader seems to take into consideration the nature of the group and the organization. He understands that some group members are dependent and expect to be told what to do while others do not. In addition, he considers the nature of the task itself. Is it structured or unstructured? Is the path to goal achievement clear and easily understood or not?

A man named Fiedler has done extensive research on the contingency theory with a large number of groups and has come up with a diagram which illustrates his findings. This diagram (Figure 1) presents what he has found to be the relationships among three important situational factors and the most effective leadership style.

Figure 1.

Situational Factors and Leadership Style

| Leader-Member Relationship | Good | | Good | | Good | | Good | | Bad | | Bad | | Bad | | Bad | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Nature of task | Structured | | | | Unstructured | | | | Structured | | | | Unstructured | | | |
| Position Power of the Leader | Strong | Weak | Strong | Weak | Strong | Weak | Strong | Weak | Strong | Weak | Strong | Weak | Strong | Weak | Strong | Weak |

The three structured factors are the nature of relations between the leader and the rest of the members (good vs. bad), the nature of the group's task (structured vs. unstructured), and the power of the leader's position over the group (strong vs. weak). Thus Fiedler defines eight different situations. For instance, consider a leader who gets along very well with his people, the nature of the group's task is structured, and the position power of the leader is strong. That, to me, is the most favorable situation of all for the leader. At the other extreme, the worst kind of leadership situation would be one in which the leader gets along poorly with the members, the task is unstructured, and the leader's position is weak. There are six situations in between these extremes. Fiedler has been able to identify successful leadership styles in each of these eight situations; his findings give support to this contingency theory. For instance, he has found that when a leader has good relationships with the members, when the nature of the task is structured, and the position power is strong, the authoritarian style of leadership is best. Why should "controlling, active, structuring" leadership, as he calls it, work best here? If the task is structured, and if the leader gets along with the group, and if he has considerable authority, yet tends to exhibit permissive, passive leadership, he probably fails to meet the expectations of the group. If one has all the leadership power, he might as well use it. And, interestingly enough, Fiedler gets the same kind of finding at the other extreme. It appears that, if the leader doesn't get along with people, if the task is unstructured, and his power is weak, if he then acts in a passive or permissive way,

the members will go in all directions. In this case, again, the most effective leadership seems to be active and authoritarian. However, Fiedler reports that the democratic style is the more effective of the two different styles in two intermediate areas: (1) where the task is unstructured, leader-member relations are good, and leader's position power is weak, and (2) where the task is structured, leader-member relations are poor, and leader's position power is strong. To me, Fiedler's work is important. First, because it makes intuitive sense; second, because it fits in with some of our own experiences that sometimes one approach works and another time some other approach works; and, third, because it is good careful research which has been done over a period of many years in both the laboratory and the field.

## Group Cohesiveness

Now I'd like to take a closer look at the group itself. An important characteristic of a group is its cohesiveness. We usually measure cohesiveness by such things as absenteeism, turnover, and tardiness. A group that is cohesive would have a lower rate of such behavior. There is more attraction between group members in a cohesive group than in a non-cohesive group. Membership in the group itself is more important in the cohesive group than in the non-cohesive group.

There are ways one can influence and manipulate cohesiveness but I want to look at the causal relationships between cohesiveness and group behavior first. Cohesive groups have the following characteristics when compared to non-cohesive groups. They evidence more aggression and hostility toward outsiders. It can be more difficult to take over leadership of a cohesive group than a non-cohesive group because, by

the very nature of the fact that they derive satisfaction simply from the group membership, cohesive group members automatically classify everybody else as an outsider. Cohesive groups evidence a greater demand for loyalty and conformity among members. Because group membership in itself is important, they expect people to conform to group norms and activities. Such groups can apply a lot of pressure to the member who does not conform. There is a danger, however, that this kind of demand for loyalty and conformity can work to stifle creativity. Cohesive groups also turn out to be much better in the communications area than non-cohesive groups. Members seem to understand each other better and they seem to communicate much more freely among themselves. Cohesive groups, because the group itself is important to them, seem to do a better job of setting realistic goals for themselves, too. Non-cohesive groups will often engage in rather erratic goal setting activities. They'll set goals that are unrealistically high or low, because the achievement of challenging goals tends to be less important to the non-cohesive group.

One feature in which we are ultimately interested as leaders and managers is productivity. There's been varied research in on-going organizations of the performance of groups that are identified as cohesive and non-cohesive. In order to understand the productivity characteristics of such groups, we have to look at the goals of each group with regard to productivity. Groups have lots of goals, not all of which are related to productivity. But by examining the productivity goals of groups, their cohesiveness, and their performance, researchers have come to the following conclusions. (Figure 2)

Figure 2.

Group Cohesiveness

| GROUP PRODUCTIVITY GOALS | HIGH COHESIVENESS | LOW COHESIVENESS |
|---|---|---|
| HIGH | Highest Productivity | ---- |
| LOW | Lowest Productivity | ---- |

The highest producing groups tend to be the high-goal, cohesive groups; the lowest producers are the low-goal cohesive groups; and the others are somewhere in between. Cohesive groups, then, tend to achieve their goals whether those goals are high or low in regard to productivity. So the best kind of situation for a leader is to have a cohesive group with goals that are consistent with his own. The worst kind for a leader is a cohesive group that has goals that are contrary to what he wants to do, because the group will strive to achieve its own goals, not his.

## Types of Power

We started off by talking about power, authority, and influence, saying that any time we are trying to influence people we are talking about some kind of power. A useful distinction has been made among the various types of power that are available in a group. While I'm going through this list, think about your own work situation, and think about the groups that you're in where you're expected to have some leadership capabilities, and think about where your strengths and weaknesses lie with regard to these various kinds of power.

The first kind of power is coercive power. Coercive power is the kind of power a leader has when his followers perceive that he has the ability to punish. The followers must perceive that the leader has that ability. If he has that ability but the followers don't perceive it, then the leader doesn't have coercive power. Secondly, the leader has to be able to do things that the followers, not the leader, perceive as punishment. You must remember that what the leader thinks is punishment may actually be perceived as reward by the followers. For instance, people in organizations do lots of things to get attention and certain kinds of punishment like verbal criticism may, therefore, be rewarding to them.

The opposite of coercive power is reward power, in which a follower perceives that his leader has the ability to mediate important rewards. But if I do have the power to reward you, yet you don't perceive that I have the power, if you think that the reward is coming from somebody else, then my reward power is not very meaningful.

I might think it a big deal to write you a letter of recommendation or a nice little certificate of achievement, but it may mean nothing to you. If it means nothing to you th n I certainly haven't exercised reward power over you. Thus, power can be highly dependent upon perception.

Referent power exists when the follower simply likes and admires his leader. There are elements of charisma in this concept, which makes it pretty hard to define. If I could tell you how to get charisma, I wouldn't be telling you for free. But it appears that a person who correctly uses reward power can increase his referent power--in other words, leaders who reward people correctly tend to find that they are liked and admired. And people who use coercive power, especially arbitrarily, can tend to decrease their referent power.

There is also legitimate power, or authority as we defined it earlier. Legitimate power occurs when the follower agrees with or is sympathetic to the system that put the leader where he is. One may be appointed leader of a group, but if the people in that group don't agree with the way he was appointed leader, then he really doesn't have much legitimate power. To the extent that people believe elections are rigged or that there is favoritism involved in somebody's appointment to an official position, that person loses his legitimate power. Again, the power of the leader is highly dependent upon his followers and their perceptions.

The final type of power is expert power. That's the one that we'd all like to think we have. Expert power is the power that a

person has because his followers perceive that the leader has information that is important. To whom? The followers. Just because someone knows a lot about dinosaur eggs, that may do nothing for his expert power unless others are especially interested in acquiring one.

Because expert power is so dependent upon the follower's perception, it is the most limited kind of power a person can have. It is also dependent upon the leader's credibility. Thus, a danger with relying on expert power is that people who have it are tempted to extend their influence into areas in which they don't have expertise. The easiest way to lose expert power is to try to pretend expertise in fields in which one is not really competent. The best ways for a leader to use his expert power is to keep it within limits, thereby increasing his referent power. If he uses this expert power unwisely, he may lose all his power.

I can't tell you about your own situation. You certainly know it better than I do. But consider that there are really five different kinds of power that you may have. Some of you have to say that you have very little, except that you have been put in a position of authority. You may have workers who are much older and experienced working for you. You may have little reward or coercive power. You may have little referent power because the workers don't seem to identify with you. You may have some expert power, but even that may be limited. And now you say, "What am I going to do?" I can only tell you what researchers have found in organizations where they have asked workers to evaluate their leaders. Workers seemed to be concerned about two leader characteristics. Is he just? Not nice, but just? And does he have enough sense to know the limits of his expertise?

A leader who can establish these two things in the minds of the people who work for him--that he's fair and that he realizes the limits of his expertise, is off to a pretty good start. From there on he can build other types of power. Once a leader can establish this kind of a relationship he can get additional power for himself simply by virtue of the fact that he is the leader.

In conclusion, let me caution you that the most important criterion upon which leadership can be evaluated, whether it be ours or someone else's, is its effectiveness; that is, to what extent does it enable the group or organization being led to achieve its goals? We ought to avoid confusing strong leadership with effective leadership. Many a strong leader has taken his group or organization or army down with him to defeat or bankruptcy or destruction. By viewing leadership as a process, however, rather than as a person, we can maintain a flexibility in behavior that can mean the difference between quiet achievement and glorious defeat.

## Procedures for Counting and Charting A Target Phoneme

William M. Diedrich, Ph.D.

Articulation therapy may be divided into two major stages, sound acquisition and carry-over. The purpose of this paper is to describe procedures which enable the speech clinician to evaluate how well the child is learning his new sound under imitative conditions during sound acquisition and how well he is using the new sound in spontaneous speech during carry-over. The third procedure describes how the child can learn to self-monitor his own conversation. In all three procedures the specified target phoneme is counted and charted in a systematic and standard manner which provides the clinician and child with sensitive feedback about the learning process (Diedrich and Irwin, 1970).

### Administration of the Sound Production Tasks (SPT)

The Sound Production Tasks (SPT) are sounds, words, and phrases spoken by the clinician and imitated by the child. The procedures used at the University of Kansas (Shelton, 1967; Elbert, 1967; and Wright, 1969) are a modification of the deep testing concept developed by McDonald (1964). The three lists in the present study are 30 items for /s/, 30 items for /z/, and 60 items for /r/ (Tables 1 and 2). The items selected for the /r/ list have been systematically arranged to surround the /r/ with different vowels and consonant contexts, e.g., front-back vowels and consonants. We are interested in describing the effect, if any, that contexts developed from coarticulation theory have on the child's learning of the /r/.

NOTE: This paper represents only one portion of the two-day presentation made by Dr. Diedrich.

Table 1.

Sound Production Tasks for /s/ and /z/

| | /s/ | /z/ |
|---|---|---|
| 1. | /us/ | buzzsaw |
| 2. | musty | some zest |
| 3. | /sae/ | can zip |
| 4. | household | doesthat |
| 5. | glasszoo | /az/ |
| 6. | your side | big zoo |
| 7. | placemat | roseland |
| 8. | missing | /zae/ |
| 9. | dog gits | cheesecake |
| 10. | housekknife | whizby |
| 11. | /s/ | will Zeke |
| 12. | get some | /uz/ |
| 13. | Bob sent | Tuesday |
| 14. | /se/ | beeswax |
| 15. | busboy | could zebras |
| 16. | classday | choosehim |
| 17. | breathe softly | wiseman |
| 18. | clean suit | Keep Zoo |
| 19. | pass that | Take Zeke |
| 20. | icerroom | roseroom |
| 21. | home soon | smooth zebra |
| 22. | husky | /z/ |
| 23. | /is/ | Oztec |
| 24. | up Sunday | got zero |
| 25. | asleep | dress zipper |
| 26. | his seat | Disneyland |
| 27. | like soup | buzzing |
| 28. | all silk | Bob zoomed |
| 29. | icewater | /zi/ |
| 30. | red sooks | Her Zebra |

Table 2.

Sound Production Task for /r/

| | | | |
|---|---|---|---|
| 1. | /ɝk/ (irk) | 31. | cooker |
| 2. | dear one | 32. | /gɝg/ (girg) |
| 3. | /kru/ (crew) | 33. | /rɑ/ (rah) |
| 4. | /ædɝ/ (adder) | 34. | /ɛɝ/ (air) |
| 5. | girl | 35. | wrong |
| 6. | paper | 36. | mother |
| 7. | rock | 37. | her |
| 8. | /kɝk/ (kirk) | 38. | more things |
| 9. | /Iɝ/ (ear) | 39. | /ri/ (ree) |
| 10. | /ɝ/ | 40. | /ugɝ/ (cooger) |
| 11. | /gru/ (grew) | 41. | read |
| 12. | beard | 42. | /dɝd/ (dird) |
| 13. | rabbit | 43. | /ɑɝ/ (are) |
| 14. | bird | 44. | /krɑ/ (krah) |
| 15. | /ɑgɝ/ (ahger) | 45. | gurgle |
| 16. | /tɝt/ (tirt) | 46. | brass |
| 17. | truck | 47. | /dri/ (dree) |
| 18. | hammer | 48. | /ɑkɝ/ (ahker) |
| 19. | /ræ/ | 49. | crock |
| 20. | turn | 50. | earn |
| 21. | gargle | 51. | /ru/ (rue) |
| 22. | /tri/ (tree) | 52. | /idɝ/ (eeder) |
| 23. | /itɝ/ (eater) | 53. | /grɑ/ (grah) |
| 24. | hurt | 54. | dirt |
| 25. | /oɝ/ (or) | 55. | /træ/ |
| 26. | /dræ/ | 56. | doorway |
| 27. | board | 57. | ran |
| 28. | fur | 58. | /ukɝ/ (coker) |
| 29. | /ætɝ/ (attar) | 59. | grey |
| 30. | grow | 60. | shirk |

Counting

Some children are given the SPT once a month and some twice a month. Last year it was given every week. We are trying to determine how often the task should be administered in order to maintain a sensitive indices of the child's learning ability. At present a sensitive index seems to be between once a week and once a month. The variables seem to be the speed of a child's learning ability in acquiring the sound and the number of times the child is seen for therapy. If seen once a week, then sampling every two weeks seems enough, if seen two or more times weekly then once a week may be indicated. Administration of the 30 items takes two and one-half minutes and the 60 items five minutes.

Charting

The number of correctly produced target phonemes on the SPT items are counted and charted (Figure 1). The chart is so designed that any phoneme may be charted by merely inserting the target phoneme between the phonetic brackets on the left vertical. Since we have been interested in generalization, the chart was so designed to accommodate the simultaneous charting of /s/ and /z/. In other words, therapy is given for the /s/ and not the /z/. By making periodic checks we can observe the changes that occur in the /z/, without any specific therapy, at the same time. Any two sounds which have similar (or non similar for that matter) distinctive features may be observed (Figure 2). The 60 item /r/ chart is illustrated in Figure 3.

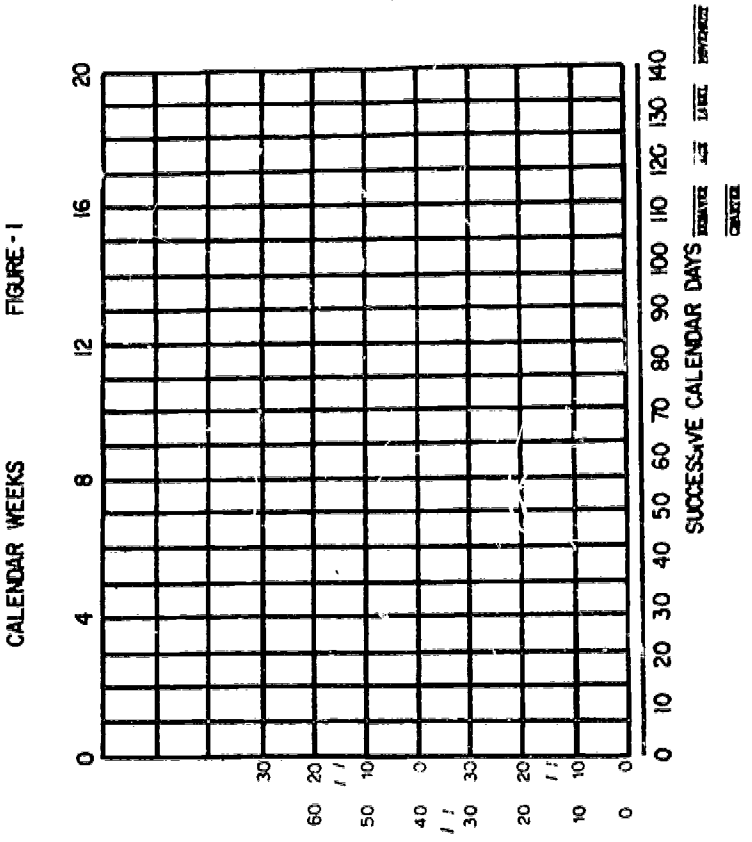

CALENDAR WEEKS
0
4
8
12
16
20
0 10 20 30 40 50 60 70 80 90 100 110 120 130 140
SUCCESSIVE CALENDAR DAYS

FIGURE - 1

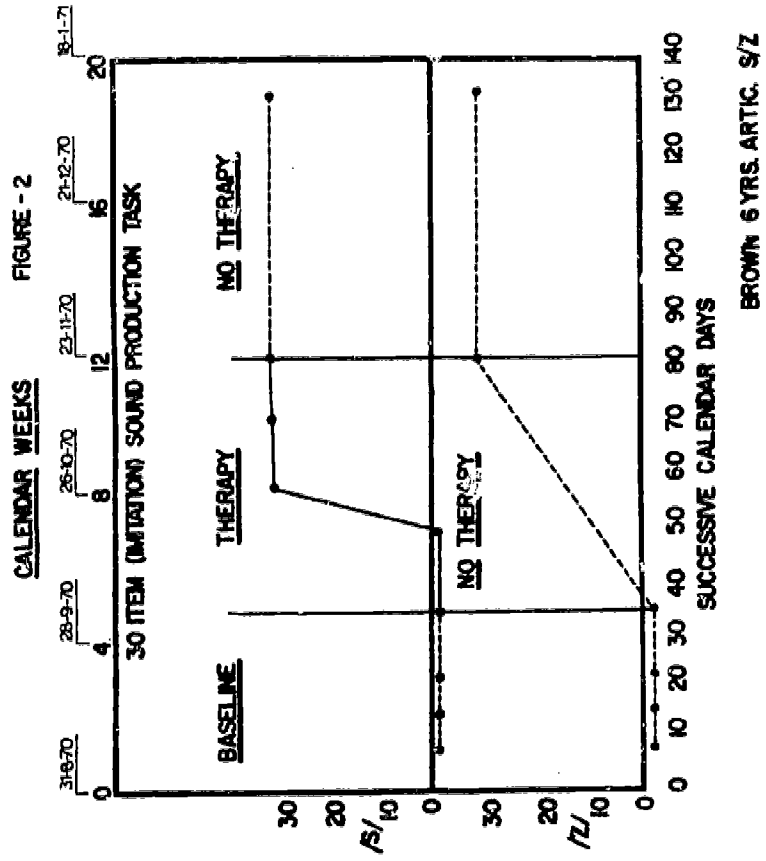

CALENDAR WEEKS
3-8-70
28-9-70
26-10-70
23-11-70
21-12-70
18-1-71
0
4
8
12
16
20
30 ITEM (IMITATION) SOUND PRODUCTION TASK
BASELINE
THERAPY
NO THERAPY
NO THERAPY
/S/ 10
/Z/ 10
0
10
20
30
40
50
60
70
80
90
100
110
120
130
140
SUCCESSIVE CALENDAR DAYS
BROWN 6 YRS. ARTIC. S/Z

FIGURE - 2

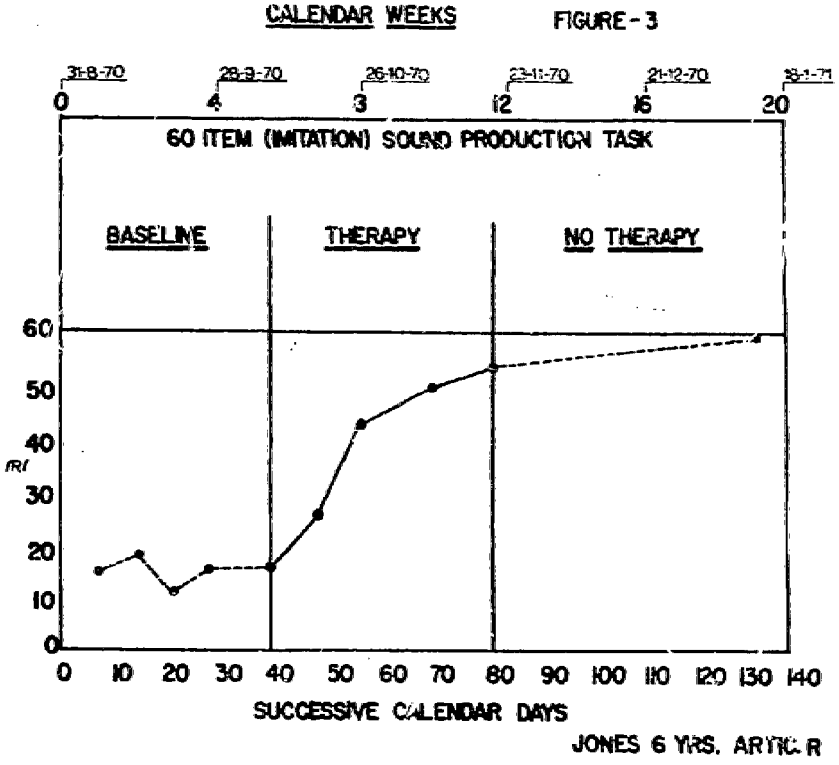

CALENDAR WEEKS
31-8-70
28-9-70
26-10-70
23-11-70
21-12-70
28-1-71
0
4
3
12
16
20
60 ITEM (IMITATION) SOUND PRODUCTION TASK
BASELINE
THERAPY
NO THERAPY
60
50
40
30
20
10
0
IRI
0 10 20 30 40 50 60 70 80 90 100 110 120 130 140
SUCCESSIVE CALENDAR DAYS
JONES 6 YRS. ARTIC. R

FIGURE - 3

Implications for Using SPT

Since sound acquisition is an important phase in articulation learning, the Sound Production Task provides a quick measure of the child's learning ability on an imitative basis. Furthermore, in the past, stimulability measures have been reliable predictors for prognosis of children's articulation learning. By the end of this project year we should have good information about the learning characteristics of children with /s/ and /r/ problems.

Since the /r/ is imbedded systematically in different phonetic contexts it provides the clinician with clues about the child's best ability in /r/ production. These contexts are then used to maximize the child's efforts in learning how to make the /r/. Word lists utilizing items which are similar to the SPT items correctly produced, or approximated, may be developed by the clinician for drill purposes.

Clinicians who have used the SPT items have suggested that spoken production of the items by the child may be providing drill activity as well as probe information, because he is given periodic opportunities for making a number of responses in a short time as well as providing him with information as to how many items he produced correctly.

To our surprise we usually have observed that the child begins to make more Correct than Wrong phonemes, during three minutes of conversation, before he achieves 100% correct on the SPT imitative items. In other words he has "cross-over" on the chart of more Correct than Wrong during a talking task before he can say all the imitative items.

This finding has important implications for our usual concepts of carry-over. That is, normally we have expected children to reach

criterion (30 Correct items on /s/ or 60 Correct on /r/) on the SPT imitative items before we begin to offer program materials for carry-over into conversation. These findings, as a result of charting during the past two years, have forced us to reassess this concept in therapy procedures. We may be keeping some children too long at an easy level of training (imitation) before we start introducing more advanced materials (practice in conversation).

## Administration of TALK

In order to determine how well the child is using his target phoneme in conversation and to record the results in a systematic manner the following methodology was developed. For purposes of discourse the word TALK refers to a procedure whereby the clinician engages a child in three minutes of conversation.

### Counting Target Phoneme

1. Engage in three minute TALK with child.
2. Clinician counts target phoneme Correct (C) and/or Wrong (W) as child is talking. Use paper/pencil to tally or purchase inexpensive counters (wrist type and others). The three minutes include whatever clinician talking is necessary to maximize the child's talking.
3. Convert three minute counts to one minute rates, i.e., the number Correct and Wrong divided by time (Correct/Time and Wrong/Time). A Conversion Chart (Table 3) is provided for this task.
4. Plot per minute Correct and Wrong counts on Chart (Figures 4 and 5).

Table 3.

A Conversion Chart for computing the per minute rate of the target phoneme sampled during three minutes of conversation with the child.

| Correct and/or Wrong Phonemes in 3 Minutes | = | Phonemes in 1 Minute | Correct and/or Wrong Phonemes in 3 Minutes | = | Phonemes in 1 Minute |
|---|---|---|---|---|---|
| 1 | = | .3 | 26 | = | 8.7 |
| 2 | = | .7 | 27 | = | 9 |
| 3 | = | 1 | 28 | = | 9.3 |
| 4 | = | 1.3 | 29 | = | 9.7 |
| 5 | = | 1.7 | 30 | = | 10 |
| 6 | = | 2 | 31 | = | 10.3 |
| 7 | = | 2.3 | 32 | = | 10.7 |
| 8 | = | 2.7 | 33 | = | 11 |
| 9 | = | 3 | 34 | = | 11.3 |
| 10 | = | 3.3 | 35 | = | 11.7 |
| 11 | = | 3.7 | 36 | = | 12 |
| 12 | = | 4 | 37 | = | 12.3 |
| 13 | = | 4.3 | 38 | = | 12.7 |
| 14 | = | 4.7 | 39 | = | 13 |
| 15 | = | 5 | 40 | = | 13.3 |
| 16 | = | 5.3 | 41 | = | 13.7 |
| 17 | = | 5.7 | 42 | = | 14 |
| 18 | = | 6 | 43 | = | 14.3 |
| 19 | = | 6.3 | 44 | = | 14.7 |
| 20 | = | 6.7 | 45 | = | 15 |
| 21 | = | 7 | 46 | = | 15.3 |
| 22 | = | 7.3 | 47 | = | 15.7 |
| 23 | = | 7.7 | 48 | = | 16 |
| 24 | = | 8 | 49 | = | 16.3 |
| 25 | = | 8.3 | 50 | = | 16.7 |

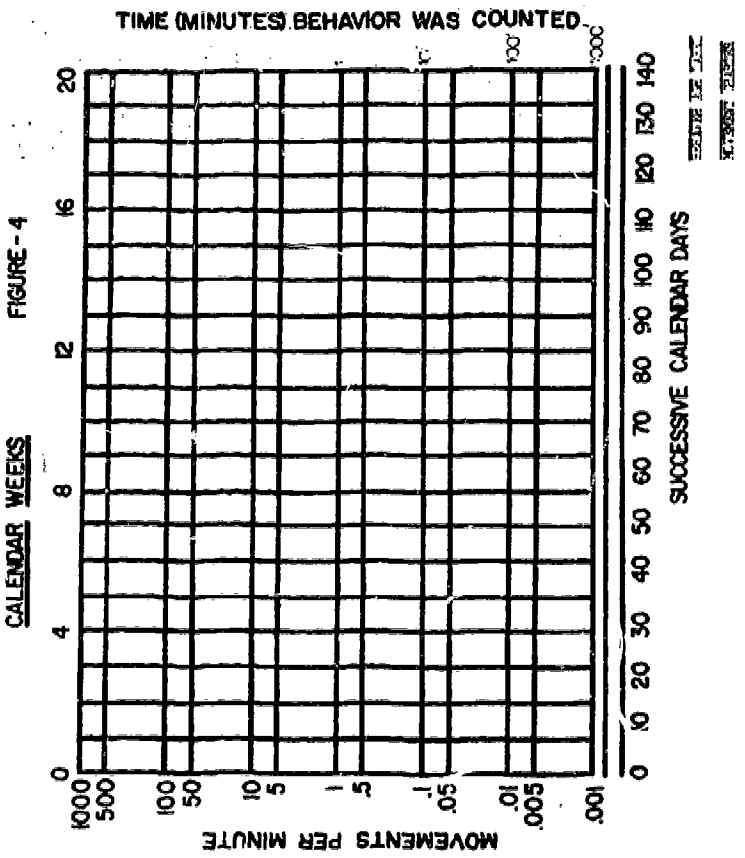
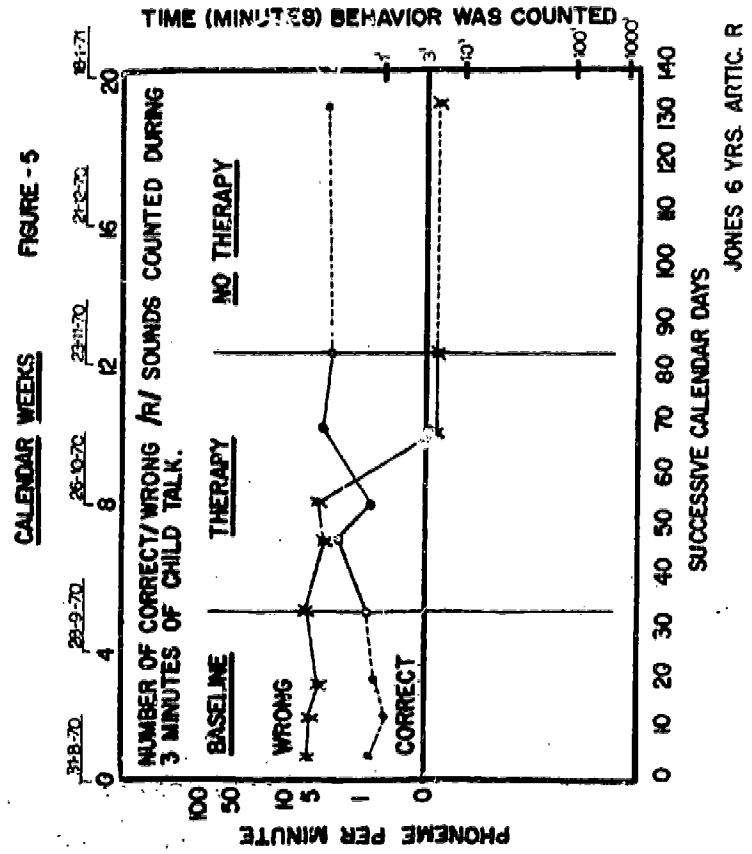

TIME (MINUTES) BEHAVIOR WAS COUNTED
CALENDAR WEEKS
0
4
8
12
16
20
MOVEMENTS PER MINUTE
1000
500
100
50
10
5
1
.5
.1
.05
.01
.005
.001
SUCCESSIVE CALENDAR DAYS
0
10
20
30
40
50
60
70
80
90
100
110
120
130
140

FIGURE - 4


TIME (MINUTES) BEHAVIOR WAS COUNTED
1'
3'
10'
100'
1000'
CALENDAR WEEKS
FIGURE - 5
NUMBER OF CORRECT/WRONG /R/ SOUNDS COUNTED DURING 3 MINUTES OF CHILD TALK.
BASELINE
THERAPY
NO THERAPY
WRONG
CORRECT
PHONEME PER MINUTE
100
50
10
5
1
0
0 10 20 30 40 50 60 70 80 90 100 110 120 130 140
SUCCESSIVE CALENDAR DAYS
JONES 6 YRS. ARTIC. R

Charting Target Phoneme

1. Time in calendar weeks at top, horizontal (20 weeks total) and successive days on bottom horizontal (140 days total). Synchronize beginning of week with beginning of school year, i.e., Sunday, August 30, 1970. Days of the week, Monday through Sunday, are indicated (Figure 4). Always plot your counts according to calendar time. If you begin in September, plot there; if in November, plot there.
2. Phoneme rate per minute is noted on the left vertical; and the Time (minutes) during which the behavior was counted is on the right vertical.
3. Determine the Floor on chart.

The floor tells reader duration of Time sample in which specified behavior (target phoneme, stuttering, etc.) was counted. To compute Floor: Divide one over the duration of the Time sample. For the three minute TALKS it is 1/3, which is .3; a line is then drawn on the horizontal at .3 to indicate this floor.

The area below the Floor is IGNORED Time for that day. In other words, counts during a three minute TALK sample, only represent three minutes of a theoretical 16 hour talking day.

4. Plot C/W per minute counts of target phoneme on the chart. Each day of the week is represented, Sunday through Saturday. Plot Correct (C) with circles/dots, and Wrong (W) with X's. It is convenient to plot Correct in Black or Green color (for "go") and Wrong in Red (for "no"). For no occurrence of the behavior (zero counts) put a circle or X just below the Floor line, not at the "0" line at the

bottom of the graph. This concept is extremely valuable for it tells the clinician and child that he has zero Correct or Wrong for the three minute sample, but not for the entir day. This is important because the FLOOR reminds the clinician and child that if the child wants to get to real zero ("0") represented by the zero at the bottom of the chart, then he must talk correctly--without errors--all day

IGNORED TIME means that the three minute TALK "ignores" how the child is talking for the rest of the day. By gradually increasing the Time when the speech is sampled and lowering the Floor, one can program the child for successive increases in amount of monitored TALK time during the day (Figure 6).

For example, first start out with the three minute TALK, then include the entire 30 minute therapy period, next a six hour school day, and finally all day. The successive floors are:

For a three minute sample, the floor equals = .3
For a thirty minute sample, the floor equals = .03
For a six hour or 360 minute sample, the floor equals = .003
For a 16 hour or 960 minute sample (approximately 1000 minutes on chart) the floor equals real zero (0) at the bottom of the chart.

5. The terms used at bottom of chart.

Movement (target behavior being counted; /s/ or /r/, etc.)
Label (pathology, i.e., articulation, stutterer, etc.)
Protege/Behavior (child whose behavior is being counted)
Manager/Charter (clinician/parent who is counting)

6. Charting speech behavior

a. Counting/charting should be done once per week (if therapy is two or more times a week) and probably twice a month for therapy done once a week.

b. Use one chart for each target phoneme studied.

c. In evaluating speech output it has been found very useful--and much more meaningful--to chart two behaviors instead of one. For articulation this means counting both Correct and Wrong for a given phoneme. Our studies of curve analysis thus far have indicated we would miss much information if only Correct or only Wrong were counted and charted. For example, we have seen charts where the Correct count of the phoneme increases but there is no decrease in the number of Wrong counts.

In observing stuttering this means counting stuttered words as well as total words spoken for a given time sample studied. For studying normal phonological frequency in children and adult speech, the word output and the frequency of occurrence of the specified phoneme should be counted.

Advantages of This Chart* and Unique Adaptation for Speech Output

1. Synchronization of calendar time--months and days, enables all children to be compared on the same time base.
2. The log chart enables behaviors which occur at different frequencies to be compared, i.e., temper tantrums one time/day, heart beat at 80 times/minute, and word output at 150-200 words/minute. Similarly speech with phoneme occurrence of less than one time/minute can be compared with a word output of 150-200 words/minute.

*Charts may be purchased through Behavior Research Co., Box 3351, Kansas City, Kansas, 66103 (1 box, 500 sheets, cost $20). For additional information on measuring and charting behavior see: Kunzelmann, H.P. (ed.) Precision Teaching, 1970, Special Child Publications, Inc., 4535 Union Bay Place, N.E., Seattle, Washington, 98105 ($5.95).

3. The chart enables one to plot a more accurate picture of the phoneme behavior, i.e., it was sampled in three minutes and not evaluated for the entire day. In other words the concept of IGNORED time is important. Standard graphs typically place 0 at bottom of chart and it is usually assumed that the behavior is "zero" if it is not seen any more, but speech is an all-day phenomenon and this chart and the notion of FLOOR reminds us to program carry-over procedures throughout the day.
4. Transformation of fleeting temporal auditory phenomenon into a visually fixed state (chart) allows for the study and understanding of speech behavior. An analogy is the audiogram (a log chart) which is used in audiology. Learning curves (acceleration rates) can be compared across clinicians and children because a standardized speech behavior measure and chart are used.
5. At midyear the charted learning curves may be used as a basis for regrouping children in the clinician's caseload. By comparing the curves on the SPT and three minute TALK charts it is possible to compose groups of children who exhibit similar learning patterns.
6. The counting/charting is easily learned and applied by clinicians in the public schools who work with large numbers of children. In fact this procedure enables the public school clinician to keep track of specific progress on individual children which heretofore may have been hit-or-miss. At the same time the record keeping takes no longer than conventional procedures.

7. The counting/charting procedures have demonstrated merit for accountability to the clinician (e.g., "I would never have known that this child was such an inconsistent learner."); to the child (e.g., "I like to watch my progress." "When I get to the bottom I can stop coming to speech therapy."); to the parent (e.g., clinicians can be very specific about the child's progress during present conferences and parents seem to understand the goals better); and supervisor/principal (e.g., charts provide visible evidence about how well the clinician and children are doing).
8. The SPT chart has the same calendar base as the TALK chart. It has been found useful to overlap (put C/W TALK chart on top of SPT chart) the two charts and observe the relationship between acquisition of the target phoneme on an imitative basis with the target phoneme in conversation.

## Procedures for Teaching Children to Make Correct and Wrong Counts of The Target Phoneme

Self-monitoring of one's speech appears to be a necessary requirement of the speaker. Many procedures have been used in speech therapy to achieve self-monitoring skills. The discussion which follows explains steps which have been developed for teaching children how to self-monitor their target phoneme during the three minute TALK.

1. Explanations. This step presumes that the child already knows that he makes sound production errors and that he knows which sound he is currently attempting to correct. The explanation step includes discussing with the child the fact that the goal of speech class

le
nec
and

2. Dem
cou
egg
equ
ind
the
kno
may
red
(e.
dem
dic
au
to
oth

3. Pre
le
duc
fol
a.

s to teach him to use the target sound correctly during all con-
ected speech. He is usually familiar with "word" tests in speech
nd you might explain that this is a "conversation" test.

emonstrations. This step includes demonstrating to the child the
ounters and the stop watch (some clinicians have used three minute
gg timers or other devices) and allowing him to manipulate the
quipment. Next, turn on the stop watch and show him how to
ndicate Correct and Wrong responses one one set of counters during
he conversational period. You need to ascertain that the child
nows which counter is for Correct and which is for Wrong. This
ay be done by 'color-coding' the counters (green for Correct and
ed for Wrong) or by indicating which hand stands for which response
e.g., right hand for Correct and left hand for Wrong). A further
emonstration might be made by the clinician using exaggerated
iction in the production of correct and wrong responses. At the
ame time the clinician shows the child how the counters are used
o indicate the Correct or Wrong response. In lieu of wrist or
ther mechanical counters, paper/pencil tallies may be used.

ractice. This step includes any methods employed while the child
s counting and learning to monitor the accuracy of his sound pro-
uctions. A variety of practice techniques may be employed. The
ollowing are some samples:

. As the child speaks the clinician responds to every production of the target sound. For example, if the child monitors his production of the sound and presses the counter correctly (for either Correct or Wrong) the clinician reinforces him for the

desired behavior. If the child presses the counter incorrectly, the clinician draws this to his attention and explains the error. If the child presses neither counter after producing his target sound (Correct or Wrong), the procedure is halted. The clinician draws the child's attention to the word and assists him in determining whether the production was Correct or Wrong and supervises him in pressing the counter which records the responses accurately. Talking is then continued.

b. The clinician may use the tape recorder to record a sample of the child's conversation and then assist him in counting the Correct and Wrong responses while both listen to the tape.

c. The child may practice listening for the sound of interest in the speech of other children in the group. He may either make a tally each time he recognizes the sound, or he may count Correct and Wrong productions.

d. In a group, not only the child who is speaking is taught to count, but the other children in the group also may count the speaker's Correct and Wrong responses. When the allotted time is completed the counts of the children are compared to the clinician's and those with the closest counts to the clinician's are praised and those who differ widely are advised as to the nature of their errors.

e. After the child learns to self-count, he is taught to plot his own chart. His counts and chart are then compared with the clinician's counting and charting. Children appear to enjoy this competitive learning arrangement.

4. When the child has learned to self-count and chart his data it is important for the clinician not to cue the child as the target phoneme is being produced during the child's talking. Since counters make noise the child usually knows when the clinician is tallying Correct/Wrong. Unless the counters are held in the lap under a notebook, or under the table, the hand movements will be observed by the child. If the clinician tallies by paper/pencil then the sound cue can be eliminated. Different positioning and postures can eliminate the visual cues.
5. After the child has learned to self-monitor his conversation (i.e., has achieved good agreement with the clinician C/W counts), he can then begin to self-record his talking for longer periods of the day. By increasing the length of time the speech is observed, and dropping the chart FLOOR, carry-over can be systematically followed (Figure 6). Tallies can be done with wrist counters, marking on masking tape attached to the sleeve or belt, or other creative ways devised by the clinician and child.
6. For checks on the child's talking away from the speech office, parents, siblings, or peers can be taught to make Correct/Wrong counts.

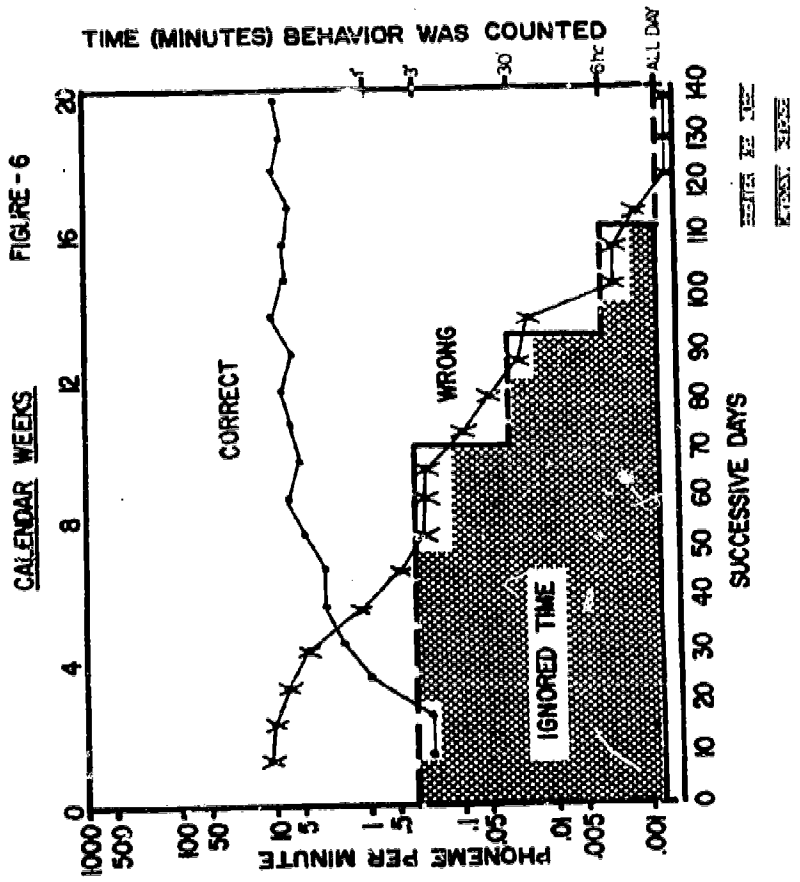

TIME (MINUTES) BEHAVIOR WAS COUNTED
1'
3'
30'
1hr
ALL DAY
CALENDAR WEEKS
0
4
8
12
16
20
CORRECT
WRONG
IGNORED TIME
PHONEME PER MINUTE
1000
500
100
50
10
5
1
.5
.1
.05
.01
.005
.001
0
10
20
30
40
50
60
70
80
90
100
110
120
130
140
SUCCESSIVE DAYS

FIGURE - 6

## Summary

This paper outlines procedures for systematically counting and charting a target phoneme from sound acquisition through carry-over. The methodology has been utilized successfully by speech clinicians in the public schools for the past two years. They have demonstrated that it takes no longer than conversational record keeping and, perhaps more importantly, provides the clinician and child with feedback about the child's progress. Furthermore, systematic and standard record keeping of this nature permits comparisons among different children, clinicians, and therapy procedures.

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## A Close Look At The Clinical Proces.

Daniel R. Boone, Ph.D.

There is something that makes a person a good teacher, something that makes a good clinician or a good speaker. I've been fascinated by the question, "What is that ingredient?" What are the qualities that differentiate the good clinician from the poor clinician?

We have tried to see what could be done to identify this x factor. If we can find out what makes people effective perhaps we can teach that skill. For the past two years, with Office of Education funding, we have been trying to identify that x factor. We have been studying speech therapy in a university clinic by video taping 22 hours of therapy a week. We have tried to find some of the typical sequences of behavior in new clinicians. We also trained the cameras on ourselves--faculty and supervisory staff--to identify some of the things that we do in a speech therapy session. I want to share with you today some of the findings from this work to add to what you've been discussing about supervision.

It appears that many individuals have the capability of self-supervision. They can learn to study themselves. In a day when people are often resistant to authority, anyone who tries to tell others what to do is going to meet some resistance. But if you can give people some framework for looking at themselves or for hearing themselves they may develop some capability for self-supervision. I'm not thinking in terms of self-supervision replacing traditional supervision, but being used adjunctively. It could be a rich experience for those who are exposed to it.

In our study, we have developed a 10-category system into which we can fit any event that takes place in speech therapy. I want to talk with you today about this 10-category system. You could add more categories but I think there's a lot of detail in the therapy session that we don't need to study. At the same time, there are some major events that we do need to study.

It appears that everything that happens between people is basically cause-and-effect or give-and-take or contingencies or whatever you want to call them. If you start shaking your head as I talk I'll change what I have to say. But if you look relatively interested and give me an occasional smile, you'll "turn me on" and I'll keep talking.

As we look at a speech therapy session, we see that behavior of the clinician and of the client are not independent events. They are highly related to one another. If I shift in my chair this may be a signal to a child that this is the end of a therapy event. We're always signalling one another in therapy (some very poor therapy and some good therapy over this two year period), we find that the majority of the talking is done by clinicians. That isn't necessarily bad. In some kinds of therapy the talking should be done by the clinician. For example, we find in our pre-school language therapy that we do a lot of talking with very little direct response from the child. So we may find in analysis of a pre-school tape that the clinician produces 75-80% of the verbal output. Now whether this is good or bad, we at least know that four-fifths of the therapy time is taken up by the clinician in saying things. How many of us know in our own therapy how much time we talk as compared to the time of the verbal responses

of the child? How many of us know in our therapy how many non-verbal cues we use? I'm beginning to realize that some of this x factor I talked about earlier is the animation and personality, as evidenced by the non-verbal actions of the client or clinician.

After two years of research, we have not reached a point where I wish to give any indications of what is good therapy and what is bad therapy. Rather, I would like to describe what happens and leave the value judgment to the individual supervisor or clinician.

One of the areas we have looked at is that of self-confrontation both with audio and video tapes. I think that we are enamored with video tape because it is different. It does enable us to see non-verbal behaviors. However, if 85% of your therapy session is verbal, audio tape has a real place as a supervisory tool. There are very few clinicians who do not have access to audio tape. So I want to cover with you today some ways that we could use a conventional tape recorder as a self-supervisory tool.

In looking into the area of self-confrontation I gained much from the literature of such other professional workers as counseling psychologists, communication specialists, clinical psychologists and social workers in the use of various methods in supervision. I was introduced to the concept of content and sequence analysis and from that we developed the matrix for looking at the events that take place in therapy. We then designed a confrontation experiment to determine if the use of video tape would be an effective method of training clinicians--1) effective in changing their concepts of self and

2) effective in their ability to make behavioral changes. We had three groups, ten people per group. The control group was assigned a normal caseload. Ten other subjects were assigned to a video confrontation group which meant that during therapy we video taped their entire therapy session. Immediately after therapy the clinician would view his video tape. In the beginning we watched 25 minutes of therapy. We soon found out that we could extract five minutes from a therapy session and get basically the same information that we could from a 25 minute confrontation. The only criterion that we had to use was that it should not be the first five minutes or the last five minutes unless we really wanted to look at how somebody approaches a client initially or how they terminate therapy. These are critical time periods but they're quite different from the major activities in therapy. So once a week for 14 weeks we taped a five minute segment from the middle 20 minutes of the therapy session. This segment was then viewed with a trainer who was assigned to our video project. Prior to the video exposure each student was given instructions about how to study himself on video tape. The student was able to stop and start the video tape as desired. The trainer was only there to comment if the students asked him to.

Our third group of ten subjects had what we call double confrontation. We made a video tape of them in therapy. As they were watching that tape with their trainer, they were again taped. So they then literally watched themselves watching themselves. This methodology has been

found to be tremendously effective in improving self-concepts of people who don't think very highly of themselves. This very complicated arrangement requires two recorders in simultaneous operation and two monitors.

Before our students began the project a number of dependent measures were given. We tried to get as much hard data as we could. We gave MMPI's. We took all background information we could such as their undergraduate grade point average. We looked at the Chicago Q Sort, a personality test which tells how someone might feel about himself. We developed a Q Sort of 100 cards to determine what is an ideal clinician. The subjects sorted the cards before and after on where they thought they were as a clinician and where they thought the ideal clinician should be. The subjects were quite a ways apart between what they thought was the ideal clinician and where they thought they were at the time of their sort. As a result of this first year, we generally found that people who had double confrontation had the greatest positive change in self image. We found that when you see yourself watching yourself for some reason you tend to view yourself with compassion. We found that, for people who appeared to have healthy or relatively normal self images, double confrontation wasn't needed. There's a big waste of time, machinery and expense, so now we do not use double confrontation except for those people who seem to evaluate themselves fairly low on such items as, "I have trouble getting my ideas out effectively to other people," or, "I don't seem to perform as well as my innate capabilities said I could." People who are very heavy in that kind of statement profited from the double confrontation.

Now both the single and the double confrontation people had an interesting development in the "ideal" and the "actual" clinician sort. Generally, if you study yourself systematically on video over a period of time, your "ideal" starts high and your "actual" starts low. With confrontation the "ideal" tends to go down and the "actual" stays about the same. You have become more realistic. In the control group, we had a slight drop in the "ideal" and a real rise in the "actual." So probably the effect of video confrontation would be that we would become more tolerant of ourselves and our possible problems.

Another part of our study was directly related to therapy. We looked at the sequence of events in therapy--when a client made a correct response what did the clinician do? Did he say, "O.K.?" Did he do nothing? We computed for each student what we call a positive reinforcement ratio. This means that if Billy says "wabbit" we don't say "good" or "fine." At first many of our clinicians did say that and they were unaware of it. The positive reinforcement that clinicians used most frequently as a filler was the expression "O.K." We use this so often. The child says "wabbit" and we say "O.K." We are unaware of it but the child doesn't forget. We found out in analyzing therapy how important the reactions of the clinician are in shaping the child's behavior. Clinicians give positive rewards. We use that terminology to mean that you do something that accelerates a behavior or makes a behavior come back--perhaps a positive head nod and a smile. Another thing clinicians do is punishment. I might add that we do not use the word punishment because we got so much resistance from our kids

that we used the terminology negative reinforcement. But we're really talking about any behavior that a clinician does that causes a behavior to decrease or stop. If I exhibit some behavior and somebody stops what they were doing as a result of my action, we would call that a negative reinforcement.

Another thing that clinicians do in therapy is neutral social conversation. It is deliberately part of the therapy session but not a specific goal of that session. Then the client does something--correct behavior--incorrect behavior. We count every time the child makes a correct response. Then we determine what percentage of those correct responses were positively reinforced. This counting can be done very quickly in a five minute tape. Perhaps 80% of all the correct reproductions were positively reinforced. This may be fine for Client A but ridiculous for Client B. But, after counting, we know that 4/5ths of our behavior in therapy with that client was positive reinforcement. And that may be too high for learning to take place.

We then looked at these clinicians to see what they did when a client made an incorrect production. How many times did they let him know that that wasn't what they wanted? This is what we call negative reinforcement. As a result of our first year of study, we found that video tape confrontation, single or double confrontation, made no difference in the amount of positive reinforcement. We did find that all of our clinicians in both the control group and the experimental group used very little negative reinforcement. Many clinicians did not use no-responses or negative reactions at all in the beginning. However, those with confrontation significantly increased their negative reinforcements. Apparently when you see that punishment is

just a matter of head nodding, head shaking, postural shift, saying "No," saying "Try it again," you are more willing to use it in therapy. We have found that our best clinicians in the clinic and in the community are the ones who are not afraid to use negative reinforcement. I would say that one characteristic of an effective clinician is his ability to punish, possibly just a head nod or head shake. We have found that one of the obvious effects of video and audio confrontation is that people become less afraid to say "No." You see, in our culture, we don't say "No." We do not use negative reinforcement very often. Many of us are far too timid, in my opinion, to use it in therapy. I think that for many clients when they are off-target they ought to know they are off-target.

But, again, after looking at all this therapy for a couple of years, I think we can definitely conclude that one characteristic of an effective clinician, somebody whose w/r cases get over their w/r substitutions, are clinicians who use punishment, some kind of feedback to the client to let him know that what he did was <u>not correct</u>.

We then decided to see if audio tape would accomplish the same thing. So the second year we divided our groups. We dropped the double confrontation group and added an audio-confrontation group. Basically we did the same thing this year and we found that audio tape is as effective as video tape in changing your self concept. However, the video tape is a far more effective way of looking at what goes on in therapy. The good and bad clinician varies in non-verbal behavior. It isn't what you say, but your expression. I think we're learning as

a whole society today about the tremendous effects of facial expression and intonation as communication media. Non-verbal cues carry much meaning and this is what is lost in the audio taping.

In our experiment with audio tape we took a video tape of the person the way I previously described to you. Then we merely turn off the picture and listen to the audio channels so we can control the quality of our audio information. There's something about seeing yourself or hearing yourself critically that makes you a little more comfortable about your capability as a clinician. I don't think we've identified exactly what it is you see or hear that does this.

Negative reinforcement ratios still shot up with people who had audio confrontation experience. I think a very critical thing in what we'll be saying from now on is this. You can watch or hear yourself on video tape by yourself and derive something from it. However, if you are taught to use some kind of a ruler or a matrix when you look at yourself it will be many more times effective. When you learn to look critically at certain events in therapy the experience will have far more power for you. We think we've developed several matrices for the clinician. We'll spend sometime this afternoon learning to score one matrix. I would like you to see the same therapy sequency on video and then listen to an audio and see what you missed.

You can't just turn on a television set and watch a tape of therapy and gain a lot from it if you're watching your own session. The advantage of tape recordings is that you have immediate playback and this immediacy must be used by a supervisor, either yourself or someone

else. On video tape you can recapture an oral posture over and over again. I can sit in the observation rooms and look at somebody make a sound and it's gone. I can't even write it down or verbally describe it. But on video tape I can stop the tape and I can show you what happened. If you are going to use video tape to look at yourself or to have others view themselves in therapy, you should try to free the equipment so you can have an immediate playback. If you wait a day or two it is less effective than if you look at yourself immediately. It is my belief at the present time that all of us would be better clinicians, perhaps better persons, if we would spend 10 minutes a week looking at ourselves or hearing ourselves. I want to show you a way that you could record your own therapy session on an audio recorder, pick out five minutes of that session and critically analyze it. If you do this every week you'll become aware, perhaps for the first time, of some of the things that you do to control behavior of the people with whom you're working. If you have access to something like video recorders, fine. If you're in a school system that has audio recorders use this method. It does not require video tape.

Someone has asked me how we determine effectiveness in therapy. Today we have to determine effectiveness by the responses of the client. If somebody's problem diminishes or ceases then we would say that clinician was effective. We have had an impossible task of trying to equate effectiveness across parameters. Articulation effectiveness is fairly easy to quantify. However it is very difficult to determine if you have or have not achieved fluency. But it is our philosophy generally, which really emerged out of video tape, that the most

effective speech therapy always starts where the client is and assures in every therapy session a high rate of correct response. So we have used the terminology can-do. We search for can-do behavior. With a pre-schooler our goal in therapy may be only to have him attend to our face. We will then reinforce attention, eye to eye contact, and looking at the clinician's face. But for each particular session we must take a baseline measure of what a person is able to do. How can we work on decreasing dysphonia if we don't have a clear goal--a target to shoot for? We search with the client for his best production or his best behavior--his can-do performance. We assess how much of that good behavior he can do and then, by whatever therapy method we want to use, we try to reach some kind of target goal.

So the therapy focus, if you were looking at video tape, would be that the clinician uses various facilitative techniques to reach a target goal. How terrible it must be for a child to go into therapy and have a failure response for 30 minutes! And how much of our therapy is built this way! It appears to me that the best therapy has 75-80% successful responses. If it's higher than that, then what we are doing is probably not difficult enough.

We see this approach in articulation therapy. The most effective articulation therapy, for instance, seems to be where the clinician searches for the client's best articulation. Effective articulation therapy, when you study a video tape, usually begins with a baseline measure in every session to determine what the child is able to do that day. We do see a lot of variability. What you do today you couldn't do last week and because of some event in your life outside of therapy, this week you can. Or, though stimulability didn't work

last week, it could work today. So part of every therapy session in our articulation therapy is often a search for what the child is able to do. When you determine what he is able to do then it appears you should make an increment of difficulty so that his success rate will not be 100% but 75-80%. We teach our students that, once a client is able to articulate correctly, he should go to rapid production-producing the sound as fast as he can. In the real world of talking we just talk and we have no awareness of where our tongue is or whether the process is being tapped or not tapped or the tongue positioned or not positioned. But in therapy session we work as rapidly as possible because that produces an automatic production which seems to facilitate carryover. However, in the analysis of a therapy sequence, the material presented should be slightly more complex than the child is able to do. If it is too complex, if the failure ratio is too high, and I'll show you how to quickly compute that this afternoon, then the material presented should be more in line with what the child is capable of doing.

I think success at an 80% ratio should be built into therapy, no matter how simple your goal may be. It may be as simple as getting him to walk into the room. You begin where somebody is (I think this is consistent with motivational psychology--there's nothing like success to breed more success). From a behavioral modification point of view, you always start with a baseline and build upon it.

Again, if I could leave one message with you it would be that the higher the failure rating of your client in therapy, the poorer the therapy session and the less effective you are as a clinician. Find out what the client can do and focus in the <u>can-do</u> area. That will

bring up the deficits more effectively than if you sit in therapy with a client who cannot name objects and have him practice naming. That's horrendous therapy. Terrible. When we do language therapy with pre-school children, once again, we try to find where it is the child functions best. And if we're around 75 to 80% successful in therapy we know that the child is working at a level compatible with his ability. If, for example, we're insisting that he say things which are beyond a pre-schooler, then we'll have a very high failure rate and with that high failure rate you will see a lot of client behavior that will almost destroy the session. The hyperactive child will be all over the room. Why? Because the task presented in therapy is too difficult. Clients are very similar to clinicians, they tend to do over and over and over that which is successful, that which has been positively reinforced. So, to be an effective clinician, we should go at a 75-80% success rate. The correct client response should be reinforced on some kind of a schedule--either one-to-one or five correct responses before we say good. Unless we have this I would say the therapy session runs a real risk of not being too effective.

We find another thing in our therapy sessions and that is that diagnosis and evaluation are part of every therapy session. We all know that but some people don't do it. When you're using a matrix of some kind you can very quickly identify the clinicians who do not do it. The matrix we use is shown in Table 1.

The ten categories are intended to be used to score video tape or audio tapes of therapy session "on the fly." That is, the behaviors of the therapist and client can be scored continuously as the tapes

Table 1.

Speech Therapy Scoring Matrix

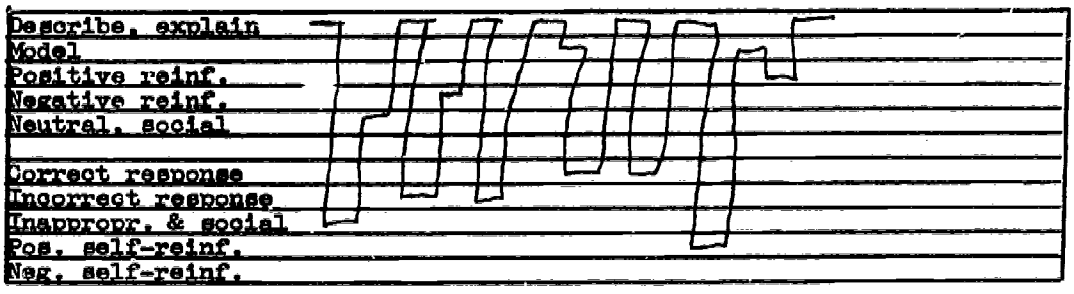
| Category Number | Title | Brief Description |
|---|---|---|
| 1 | Describe, explain | Therapist elicits client behavior by description, explanation or by direct control |
| 2 | Model | Therapist elicits client behavior by direct and conscious modeling |
| 3 | Positive reinforcer | Therapist positively reinforces the client, either verbally or non-verbally |
| 4 | Negative reinforcer | Therapist negatively reinforces the client, either verbally or non-verbally |
| 5 | Neutral and/or social | Therapist engages in activities which do not require client response or which deal with session goals |
| 6 | Correct responses | Client makes a response which is correct in terms of the therapy goals |
| 7 | Incorrect responses | Client makes a response which is incorrect in terms of the therapy goals |
| 8 | Inappropriate and/or social | Client makes a response which is not appropriate in terms of the therapist's goals or engages in social conversation not related to the therapy goals |
| 9 | Positive self-reinforcement | Client positively reinforces himself by verbally or non-verbally indicating that he considers his response correct |
| 10 | Negative self-reinforcement | Client negatively reinforces himself by verbally or non-verbally indicating that he considers his response correct |

are played. It may help to have a switch to turn off the tape machine if you get behind the scoring, but after about 30 minutes practice, most people are fast enough to stay up with all but the most rapid sequences of interaction. Rapid scoring requires practice, but there is also a way of scoring the interactions on a form which permits the fastest possible recording.

A typical recording form is shown in Figure 1. It consists of ten lines, one for each category. The therapist categories (1-5) and the client categories (6-10), are separated by an extra space to help keep the sections of the scoring form clear and obvious. The fastest and easiest way of scoring is also illustrated below. This method consists of making a short horizontal line (about the length of a dash - ) for each act and then drawing a vertical line to the next category. Some people begin scoring by placing a dot or x in each category as it occurs, but this tends to be a slower process than the continuous line method. The vertical line method of continuous drawing is faster for the same reason that script writing is faster than printing: you don't have to make as many sharp and distinct changes in the movement of your hands and fingers.

Figure 1.

Recording Form



The recording form allows continuous scoring of the acts on a session as they occur in sequences. This is important because part of the value of the recording system is to allow you to analyze the sequence of acts or behaviors as they occur. It is of some interest to know how many acts of different kinds show up in one therapy session, but it is much more useful to know in what order they occur. Therefore, it is important to score the therapy session continuously and keeping the acts in the sequence in which they occur.

What constitutes a unit of behavior on a video tape? The rule in this regard is fairly simple. Record every change in the type of activity or behavior that logically falls into another category. For example, assume that the therapist begins with: "Okay, Johnny, I want you to start by trying to say a word. Say, 'rabbit." This begins with a Category 1 (describe and explain) act and goes into a Category 2 (model). Now assume that another therapist begins this way: "Okay Johnny, I want you to start by trying to say some words. These are easy words that we worked on last time, and I don't think you'll have any trouble with them. In fact, I think you'll have fun. Start by saying 'rabbit." This sequence would be scored exactly as the previous one. Even though there are three distinct sentences or thought units in the beginning, they are all Category 1 statements. So you start with a Category 1 and go to a Category 2.

In addition to recording every change in the type of activity, be sure to record every alternation between client and therapist. This is

important in order to establish the full sequence of interaction. Naturally, any shift from the therapist to client or vice versa is automatically a shift in category because of the way the category system is set up. Remember that we are interested in non-verbal behavior as well as utterances. Therefore, each smile, frown, nod, shake, and so on, constitutes a unit to be scored in the category system.

We were concerned in the beginning about our system because we weren't taking account of time. We were counting events. Sometimes we explain and describe for a long time. So one of our graduate students worked on this project, timing the events to see if we needed to plot the time. We found, however, that time correlates so closely with the number of events that you don't need to bother with time. This is just a way of looking at the session. If you see that one individual clinician is spending a lot of time explaining and describing you will see a lot of events marked under explain and describe. And you can ask, "I wonder why you have to explain this one so often." Well, usually the reason you explain things often is that Category 7, failure to respond, is occurring. So you explain it over again. Now you may say, "Well, it seems to me that if you had taken a baseline in that particular session and looked at what you wanted to do first before you presented your models and your instruction that you wouldn't have to have a high number of incorrect responses. We say that, if 30% of the responses are incorrect, that's too many. And the clinician says, "You said 75-80% might be correct and now you say 30% incorrect." Well, there is a slight overlap. I'd say that if over 30% of the child's responses are incorrect, then what he is asked is too complex. Then the task ought to be simplified.

Let's respond to your questions now.

Question: "Do you use this to look at group therapy as well as individual?"

Answer: In looking at groups we've used different colors. That's the only way it would work. Let's say Billy is red, John is blue and Mary is green. This is not the most effective thing for groups. It really is not. It's tremendous for individuals but it is difficult to apply to groups. We have used color coding. We might look at one minute or a minute and a half of the group and try to see what each child is doing. And it's kind of interesting how one child will have parallel activity to another child and maybe the third is a complete loner. The categories are down here and everyone else is up here. You could quickly identify numbers not responding. We're developing a methodology to use it with groups and it looks like it will have to be color coded. We try to make it as simple as possible. If it becomes too complex, people are not going to use it.

Question: "In a statement a little while ago you said for better learning success about one out of five responses should be error and then you said you should start with what the client can do and then involve yourself in a can-do therapy. Are you then operating on the assumption that this normal human behavior can-do therapy will produce 20% error or do you ask the therapist to try and consider the potential error performance in the activity she planned?"

Answer: In the area of can-do, when you do your baseline assessment that baseline is basically 100%. Then you get off the baseline as soon as possible and you increase the complexity of the task just slightly. That's when you start to have 20-25% error. You get off the baseline in the search for what he can do rather than any attempt to evaluate what he can't do.

With a "functional" kind of problem, the assumption is that eventually he ought to be able to do what is acceptable all the time. So then you get closer to the goal where the client can do almost all the kinds of activities you can dream up. When he's at 100% mastery of complexities in therapy then I think we would have very clear graphic evidence that therapy, at least for that task, ought to be terminated.

Question: "But as you get to this then you have another dimension to consider in this kind of structure because you've got a nonreward kind of behavior."

Answer: One of our categories is self-reinforcement. Once the client starts making that old distorted sound correctly, self-reinforcement usually takes over and not much clinician reinforcement is required. Self-reinforcement generally becomes a pattern during the end stages of therapy.

## Summary

All self-governing systems require feedback. Feedback is a basic characteristic of all social and biological organisms. It is recognized as an essential part of the learning process. Many educational procedures such as tests, report cards, the grading of papers, and the like are used, to some extent at least, to provide students with information or feedback about how they are doing. VTR self-confrontation has the advantage over most other feedback methods of being highly accurate and thorough. It can provide an individual with a rather complete and highly objective replay of his past behavior. Theoretically, such feedback should facilitate the learning process by enabling the individual to modify his future behavior on the basis of his past performance, and his future behavior can also be video tape recorded for feedback purposes. By demonstrating the positive effects of VTR self-confrontation, the present investigation certainly supports the validity of feedback theory and emphasizes its important role in the learning process.

While not overly dramatic in its effects, double confrontation had a measurable and distinctive impact on the subjects. In the single confrontation condition, subjects viewed their performance as clinicians. In the double con-condition they viewed themselves viewing their clinical performance. Since the findings indicate that learning occurred during single confrontation, it could be said that double confrontation subjects watched themselves learning. It is conceivable, then, that double confrontation provides an opportunity for individuals to learn about how they learn. The implications of such a feedback process are many. Additional research into the effects of double confrontation should be conducted.

The video tape recorder is a relatively new piece of educational hardware. In recent years it has become an important part of the educational scene. It is being used at a number of institutions in the training of teachers, counselors, clinical psychologists, medical doctors, lawyers, speech therapists and public speakers. It is also employed extensively by industry for in-service training purposes. However, very little of a scientific nature is known about alternative ways to use the video tape recorder or its relative effectiveness. The present study represents one of the few systematic attempts to develop a specific VTR methodology for self-confrontation and to test its effectiveness. The findings are encouraging. They suggest that VTR self-confrontation is a practical and feasible educational methodology and that its effects can be distinguished from more traditional educational approaches. The study lends further support to the age old dictum that true learning begins with self-knowledge and understanding.

## Human Relationships in Supervision

Norman Kagan, Ph.D.

I'm going to talk with you about how you teach someone else to establish a relationship which, though it may not necessarily be a therapy relationship, at least has therapeutic potential or therapeutic elements. This is a problem which is faced by more than those of us who are in counseling and psychology. I have an appointment in the medical school and there they are concerned about the same thing. How do you train a medical student so that, when he sits down with a patient, he can have a therapeutic impact on that patient--a psychotherapeutic impact on the average kind of person who comes to him. Psychotherapy is a bad name for a process we all need, that is, someone else listening to us and helping us think through where we are, who we are and how to make the decisions we face. There are people who are badly crippled in these areas and who are in need of psychotherapy. But almost everyone in this world needs a good friend frequently. And, as professionals, that kind of function needs to pervade our work much more than it has--the function of good friend, therapist, counselor. There's another side to the coin. The person who can establish what, for want of a better word we'll call the therapeutic relationship--the helping relationship--is not only likely to be able to help another person think through his feelings, attitudes, values, and beliefs more effectively. He is also likely to conduct a better interview. He is apt to get more accurate, more complete data from the individual in almost any area. Physicians who are trained in these kinds of interview skills end up hearing more accurately from patients the full

nature of their physical illness. The physician who is trained in these kinds of interview skills and who can communicate to his patient, "I am really interested. I am really trying to hear what you have to say. I really do want to know what makes you tick as a human being, physically and emotionally," is likely to come up with a better diagnosis. We have no hard data to support this, just lots of clinical observation.

I guess I'm giving you a sales pitch about why we ought to be looking at the way we, as supervisors and educators, can help those professionals we're preparing to learn to enter into a therapeutic relationship, in addition to their other skills. Being convinced that this ought to be done, and doing it are different bags completely. Now that we've stated this we can go home and sit with a group of our people and shout at them as I have shouted at you about the importance of establishing a therapeutic relationship. They'll go out and they'll tell other people about how important it is and none of us will be doing any of it. Of course, in counseling and psychology it becomes particularly important that we learn ways to establish a therapeutic relationship. For years and years we talked <u>at</u> people. Then we inaugurated the demonstration. We would bring in a client in front of a group and interview him. They call it modeling now. It had some advantages. It had some disadvantages, too. One is that people usually go out and imitate the wrong thing. If the therapist was smoking a pipe, they bought a pipe and now they know how to look like a therapist. Maybe they'll say a couple of ah-huh's, but they've really quite missed the point.

I don't want to knock the supervisory relationship based on this kind of experience completely. Occasionally a person could, from the

way in which the supervisor related to him, get a certain kind of feel for what a productive relationship is like by experiencing it. This has been observed often enough. Freud's notion that the psychoanalyst should be psychonalyzed moved us more and more into process experiences for the person in developing certain skills. That has now reached its peak in the T-group--the confrontation group. Everybody is in a T-group, looking at his feelings and experiencing a meaningful kind of relationship. I think this has a great deal of importance and a great deal of value. But it has some limitations. I'm going to lay out the problem as we've wrestled with it over the past several years in searching for better and better ways to accomplish certain goals. One of the limitations of the T-group is that it can be great or it can be a bomb. Or, you can <u>feel</u> that it is great and it can really be a bomb, depending upon who's running it. We have some data to support this. We took one eight-day laboratory of 80 people in T-groups all over the building. They got together as a total community and it was a wild therapeutic eight days. We gave empathy scales the first day and the last day because, if you learn anything from this type of experience, you should increase in empathy--the ability to feel what another person is feeling. And, indeed, there was a significant growth for the total group. But when we started looking at sub-groups, we found that some had made dramatic and fairly consistent gains while other groups had consistently gone down as a group. This has been supported now by the findings of Carkhuff, who found that a poor therapist not only does no good. He literally can make someone <u>less</u> sensitive than he was. When the group

members start getting into something really meaningful, in very subtle ways, he says, "Shame, shame" or "I don't really want to hear about that." As a person really begins to get into something important, the therapist simply says, "You know, let's go back to the thing you were talking about a minute ago." Enough of that and it begins to click on some subtle level that one does not talk about certain things. Or the timing interpretation often serves the function of cutting off communication. The T-group technique that does this beautifully is "Ah, ha! What's happening in our group right now?" Someone gets into something that really hurts and suddenly the leader decides to process. So now the group goes into a big cognitive analysis of where they are. The members of the group soon learn not to talk about meaningful things. Basically, then, the T-group can be great or not depending on who's doing it. Also, many, many people don't catch the message even after a good T-group experience. Yes, their sensitivity is increased. They have had a wonderful experience with a group of adults where they've learned a great deal about themselves, how other adults feel about them, how they feel about each other. They have actually learned some new behaviors. For example, they began trying to be more aggressive if they felt they had been too timid or they've tried shutting up for awhile if they were too aggressive. However, often they do not see clearly the relationship between that learning and the ten-year olds with whom they work. We assume that there'll be generalization to other situations but often, even after a good experience, it doesn't click. Ten-year olds are just different enough that the things they learned about themselves don't quite transfer. One reason we prefer to use group

therapy as well as one-to-one is that at the end of the one-to-one experience, the person often came out saying "God, that was wonderful. I found a person with whom I could be great and different. With all other people, though, I wouldn't dare it." There's often no generalization and this is a terrible thing. This is why our process measures often give us significance but, when we follow through on behavior out there, we haven't quite helped them make the transition for other situations and they haven't made it for themselves. So there needs to be translation to the specific situation.

The other thing is, we tend to swing on pendulums and when we give up the didactic "Here's how you do it" approach, we give up the lecture. We may say the only way you learn to become more sensitive with other people is to get into a T-group. Everything else is worthless. We put you in a group and you look at your guts and that's the way you become a better supervisor. That's an unfortunate swing of the pendulum because we are not just affective beasts; we are also cognitive beasts. We think. We need more understanding of what it is we are trying to get through an affective kind of experience. It would be easier to achieve this understanding if we had some cognitive guidelines and if we knew what kinds of outcome behavior we were trying to develop. For example, if you are trying to prepare me to be a supervisor, it would help me if I knew what you would like me to be able to do with my clients and if you would remind me of it periodically. But one of our difficulties is that we have tended to throw out the cognitive.

## Use of Television

About six or seven years ago, my colleagues and I began using television. We video taped some of the speeches for some NDEA institutes

we were holding so that we could play the tape back to the students during the year. We then asked the speakers if they would like to see the video tape we had just made. As they viewed themselves, we saw something interesting as we stood back and watched them look at themselves. They would say the same kind of things that we had thought about them--"Gee, I'm stiff." "I look down my nose when I talk." "I don't convey much respect for my audience." We began to realize that there was a marvelous opportunity for self-study in immediate video play back.

As we thought about this, we began to say, "If this would work, what a fantastic way to train therapists." We video taped clients and counselors. We then had the counselor leave the room, one of us went in with the client, played back the video tape on a stop-start basis and asked the clients what they were thinking and what they were feeling at that specific time. We were not attempting to evaluate the counselor but just to help him see what the client was feeling. This turned out to be fantastic feedback. Clients were able to look at themselves and remember, in unbelievable detail, their thoughts and feelings.

We also had a great deal of self-confrontation going on. A client would look at himself and, given the freedom, would begin by saying, "What I'm saying is so different from what I'm feeling. Anyone looking at me should know what I'm feeling." In other words, you know yourself. You can see through yourself and you assume that other people can. But when you see yourself on video tape, you recognize, in ways that probably

no one else would, the ways in which you're defending or hiding. So we found that if we let people look at themselves instead of having the therapist do a lot of interpreting they could do a great deal of self-discovery, both positive and negative. They might say, "Oh, dear, that wasn't what I meant to say," or "You know, I don't think of myself as coming through very strong but I look pretty good there."

To make a long story short, we went through an entire process of this. We did some very extensive control studies for a period of about a year with our students. Many people learned a great deal; some people learned very, very little. For some it was an extremely threatening experience. That is, here they sit with their client. In comes someone else, goes over the video tape with their client, and they end up with a recording which has a lot of data on it, much of which is confusing. They're not sure what they're hearing or what to do with it. It was not at all uncommon to have junior high school kids honestly say things like, "I had the feeling that the therapist or the counselor was scared here, so I changed the subject." "I had the feeling at this point that the therapist wanted me to tell him that I like him so I told him something nice about what he's doing." "I had the feeling that the therapist really wasn't interested in the vocational decisions I'm making, that he really wanted to talk about my mother or something, so I talked about my mother." As a beginning counselor, when you hear the 13 year old client talking this way, it can be pretty devastating. We found we had some students who were taking tranquilizers before they

went in! We realized we had a pretty potent tool and we had become so enamored with the potency of the media that we had let the media become a thing unto itself instead of a tool. That led us into a whole series of other experiences.

Elements of the Supervisory Process

Let me describe a sequence that we got into to teach certain elements of the supervisory process. We first analyzed what we want our counselors to be able to do. Are there any fairly concrete kinds of things that we can identify which separate the effective communicator from the less effective communicator? Can we identify any common characteristics of the physician or the therapist who is the kind of person we'd like to train? Are there things he does or doesn't do that we wish to build into the training we are doing? We looked at a lot of video tapes that we had. We searched the literature to see what was available there. We talked to clients about interviews they had which they felt were good and some which they felt were a waste of time. And then we went back to the interview itself.

What we found was that the more effective person tends to deal with the affective elements of the client's communication more often than does the less effective. That is, the client says something that, although it has cognitive element, is also a body state. It's a mood. Feeling goes with it. The most effective communicator tends to at least occasionally recognize the affective elements and communicate about them. "Gee, I hear what you're saying. You sound mad about the thing you're talking about." "I hear what you're saying and I notice that your voice tends to drop and you get very quiet as you say these things."

That is dealing with the affective components--"I hear what you're saying, but what are you feeling as you say it?" Although the therapist does not deal with the affective elements of every statement that the client makes, the effective therapist does deal with them more often than the ineffective. In a deep psychotherapeutic kind of relationship it might be as high as 17 out of 20 responses dealing with feeling tone; in an effective medical interview, it might be as few as four out of 20 responses.

Another characteristic was that, with the affective or the cognitive elements, the effective communicator communicates understanding. It's not enough that he knows he hears what's being said. He lets the other person know that he hears it, that he understands. We believe this communication of understanding is exceedingly important. It makes all sorts of sense, because not being heard is one of our more frequent experiences in society. Most people don't hear us as we talk. They don't hear the cognitive or the affective elements of what we're saying. We don't really listen to each other. I tell you about how much I hurt and you're just waiting for me to finish so you can tell me how much you hurt. I tell you about my parents and you wait, and say, "You think you had it rough. Let me tell you." When somebody really listens to you, you are encouraged to go on and tell more.

A third characteristic was that the effective communicator tended to be specific rather than nonspecific about what he was hearing. He tended to label honestly, even when it would be rough for the other person. It's calling anger, "anger," not irritation. It's calling lust, "lust," not affection. It's calling ugliness, "ugliness," and beauty, "beauty," not shying away from something because it happens to be

strong or intense. The less effective communicators frequently mellowed things out, washed what the client had said and gave it back to him in very clean, nice terms which stripped away the richness and the intensity of what the other person was trying to say. This can be a good way to make enemies or to get fired from your job but the effective communicators tended to do it. You cannot, of course, do all of these things promiscuously but you use them appropriately.

The final characteristic of the people we were able to identify clearly was something we called exploratory. The responses of the person to the client was such that it encouraged the client to go further, to accept or reject, to wrestle on. They didn't come through with such statements as "Your problem really is--". They were more apt to say, "Gee, it sounds as if--. What do you think?" That is, they were constantly saying, "Here is the way it sounds to me. Now, you wrestle with it." They almost intuitively recognized that, unless the person begins discovering things for himself with the therapist, not much is going to happen. All we know about learning tells us that, to learn really important things, one must be actively involved. Despite some of the recent work in therapy on simple behavioristic reinforcements, I am convinced that we must be actively involved in the discovery process if we are to change complex behaviors such as understanding ourselves.

## Teaching the Elements of Supervision

Having identified these elements, we then had to ask ourselves, "How do you teach people to do these things?" We decided that the first need is for our people to become really acquainted with the elements I have

just discussed. The first experience we set up is a series of video tapes of other people interviewing. We give them a rating sheet which has the elements on it. And we say, "Look at someone else interviewing. Listen to what the client said. Look at what the counselor did in response. Now, did the counselor deal with the affective? Did the counselor communicate understanding? Was he specific? Was he exploratory?" They rate every statement on all four of these characteristics in many video tapes. At the end of a few sessions of this they have a pretty clear notion of this aspect of the interviewing situation.

Please remember, I'm presenting these elements not only as a developmental sequence, but also hopefully as a kind of model. That is, for the people you're supervising, it might be appropriate to throw out some of the elements that I've given. There's nothing sacred about this whole approach except as a model which worked for us.

The next experience is to help the student recognize ways in which they trip over their own feet, the ways in which they assure their own defeat. We set up an interview for them, video taped it, and then asked the client to leave. We then played the video tape back for the trainee, but under a very, very low pressure, low threat situation where the supervisor will not interpret but will ask such questions as "What were you feeling? What were you thinking? What were you trying to get the client to think or feel about you? What did you feel about the client? Were you tempted anywhere along the line to do anything a different way? Do you remember what you were feeling?" Notice that none of these questions become, "You know what you really should have done at that point is--?" They all were, "Hey, tell me about <u>you</u>. Tell <u>you</u> about

you and tell me about you." Given this kind of encouragement and interrogation, things began to happen. Counselors who appeared not to understand what was going on between them and their client came up with the most fantastic kinds of understandings which they had, but which they did not reveal to the client or to the person observing them. People need much less "telling" about what is going on in terms of dynamics than we think. They know and feel on some level. They just don't know what to do with it or are afraid to do anything. I've seen medical students on video tape when it looked as though they really had no understanding of the subtle element of the relationship between themselves and the patient. However, on recall they have stopped the playback and said, "I had the feeling that what the person was really feeling was a great deal of pain. He was ready to cry or was going in this or that direction. But I chose not to deal with it." "Okay, why did you choose not to deal with it?" "I might hurt the other person. If the other person began to cry, I would have to sit there and feel that I had made her cry. The person might not like the experience and might not come back and that would have hurt me." Because medical students frequently want the client to think they are older and wiser, they sit and look as though they really understand everything being said. And the funny thing is that, while they're sitting there worrying about how to impress the patient, they are often literally not hearing what the patient is saying. We see this with teachers frequently. They miss the puzzled look or the kid's face because they're so hung up on, "What will I say next?" "How do I deal with this?" Often the teacher is looking at the child and not seeing or hearing. It is an amazing kind of "tuning out" phenomena.

So you have two things at work. One is the "tuning out" which typically comes where the beginning counselor is spending a tremendous amount of time worrying about impressing the other person, rather than relaxing and looking at him. The other phenomenon is what I call "feigning clinical naivete," pretending not to understand that which they really do. That's not so unusual, by the way, as it sounds. That is a normal part of socialization. You and I have been taught from earliest childhood to pick up subtle cues. Everyone of us is a potentially fantastic therapist because we have learned to pick up from each other the most subtle readings. But we've also been taught to then pretend we didn't hear it, to react but then fake it. For instance, I meet you and you say to me, "How are things at home?" and I say, "Oh, all right." You have caught the message that things are lousy but as a socialized human being you also know that you should shift gears. So on the one level you read it and on the other level you say, "Ah, that's nice. And how are things at work?" That's an exaggeration but that's what we do constantly. That's socialization. We look at each other and we recognize the messages and then pretend that they're something else. You almost have to or you don't live through childhood.

Well, let me now just summarize briefly the supervisory training program. First, to acquaint people with the elements of effective communication, we let them look at video tapes of different people communicating, rate the people they saw, and, finally, to look at themselves. We've not actually had them rating themselves in that

first interview but we have had them rating themselves in role playing experiences. After they've done a lot of rating we have them role play with each other, look at the video tape of the role playing and rate themselves. After that first experience, they look at their own recall and this is where they begin to get some understanding. The number of sessions that you do is entirely dependent upon the person you're supervising. Presumably, after these experiences, he has some understanding of the ways in which he does not do the things he would like to do.

Often when we put him back in with the same client or other clients, he's made a lot of improvement but not quite as much as we'd like. How can we help him go further? The most typical problem that these young people have is learning that one can be aggressive without being hostile. They do not understand that, when you are in the role of a helping person, pursuing something with someone is not a destructive, cruel thing to do. We have to teach them to pursue something aggressively, to become actively involved and realize that it will not destroy the other person. Again, there's a video technique that just seemed to naturally emerge in helping to develop the interrogator role that I mentioned previously--where your job is to push without interpreting, to say, "Come on, now, what were you thinking? What were you feeling?" We give people a brief training session on this, so that they really understand the role. We then have two people team up. One interviews the client; the other observes. Then the first interviewer leaves, the second goes in and goes over that video tape with the client. He will say, "What were you thinking? What were you feeling? What do you think he was trying

to get at? What were you trying to get at? What else went through your mind?" Aided with the video tape and the fact that it's not his client, people generally learn to take the chance of pushing and being more aggressive. Inevitably at the end of a session like that they come out saying, "Gee, you know I pushed hard and the client really learned a lot. I thought all these insights and understandings might hurt him but they didn't." In essence, the person has tried on more aggressive behavior and found that it can work, has found that he can be more professionally aggressive. We then do the recall experience with the client. The supervisor observes and at the end of a session asks the trainees what they have learned in the interrogator role. We found that this method of letting trainees go over a video tape with another person gives them enough of a crutch to enable them to "try on" some other kinds of behaviors.

So now he's acquainted with the elements, he's gotten some understandings of the ways in which he filters or tunes out, the ways in which he tries to impress others, the ways in which he blocks. He's been given some practice now at new modes of behavior. What we do now is to start having him concentrate on feedback. Now he's ready to hear someone else do recall with his client. He may listen in or watch through one-way glass or listen to an audio recording of a recall session at this point. He's ready to listen to the impact he was having on his client and for it to have some meaning to him to hear where he connected and where he didn't connect, to check out some of his hunches. He becomes more and more acquainted with the impact of the things he's

doing. Because, up to this time, all we've been doing is having him look at himself and teach himself certain things. Until this point we've really not concentrated on what is happening to the client. But now, if he's gone successfully through all the early stages, he is ready to listen to the client without it being too devastating to him.

Then we get to the final stage in our current developmental sequence. And that is the thing that separates the men from the boys even among competent, experienced psychotherapists. That is the ability to deal honestly with the here and now. The relationship which exists in therapy is the most real and honest example of the way in which the client does or does not enter into human relationships. It's silly for me to sit and talk with a client about what happens between him and his father, an item that may be important at some stage, and to miss completely what's happening between him and me. What's he doing with me? What does he feel with me? What are his expectations of me? What does he want me to think about him? What is he afraid I might think about him? Isn't it foolish for me to listen to him talk only about what happens to him under stress out there and miss completely the subtle on-going stresses of the here and now between him and me; to talk about his fears and not recognize when he gets pale when we are talking; to not recognize when his face begins to shine and his palms begin to show little beads of perspiration; to not recognize the frowns; to not recognize the way he looks when I stop to think for a moment, almost frightened to death of what I might say next. But how do you teach people to

do this? This is the toughy. When we went out and looked at therapists who have been in practice for years, the inability to do this often separated the therapists who really could make changes in a client's life from the ones who couldn't.

After running many video recall sessions, we began trying to determine if there were any generalizations one can make about what people seem to be doing in these sessions, whether clients or counselors or physicians. We found many of them. The "tuning out" that I mentioned is one, particularly as you become introspective and begin to think about yourself or about what to do with what the other person is saying. It became apparent that one of the more effective kinds of things to teach people about interviewing was to concentrate more on what the person is saying and less on being clever with what he's saying. If you can't do this you are going to miss a great deal that is important. Not only that, but they get subtle cues that you're really not listening to them. There's very little hiding place in human interaction.

Another I mentioned to you before is the feigning of naivete'-- pretending that we haven't seen and heard things that we really have. The third thing that came out was the extreme importance of the here and now. No matter what a client is talking about in terms of life out there or problems out there, that client is looking at the counselor and saying, "I wonder what he thinks of me. I wonder what he's thinking about what I'm saying. Here is what I want him to think about what I'm saying." That can consume most of the client's emotional energy in the situation. So the most appropriate basis for helping the client understand himself, is to deal either immediately or as soon as possible with

the I-thou relationship. "Look what's happening between us and how does this relate to what goes on out there."

## Use of Simulation

The next things that came out, session after session, led us to the use of simulation materials. It seemed to us that there was a great deal of commonality in what people said they were concerned about in relating to other people. There was a concern that could be generalized as, "If I get close to this other person, he will hurt me. If I drop my defenses, I allow myself to become interpersonally involved. If I let myself go, I will be vulnerable. He will hurt me. I will get hurt." For each person it took on a different specific story. "I'll be insulted." "He'll treat me just like my father used to treat me." "He'll tell me I'm not so smart." "He'll tell me I'm stupid." "He'll tell me I'm ugly." Similarly, "If I allow my defenses to fall down, you might do something that's just as frightening. You might become affectionate." That can be just as frightening as if you became hostile or aggressive, even more so for some people. Then there's the other side of the coin that we heard from all people to some extent, "If I allow my defenses to drop, I may hurt the other person. I may hurt the person I'm talking with in one way or another. If I'm not careful I may do harm." This goes all the way from hurting his feelings to killing him, depending on the individual. You can see what the next one is. "If I'm not careful my affectionate-dependency needs might show through and I might become affectionate, seductive, dependent. Somehow I might get closer than I should get."

So we asked ourselves if we could simulate the fairly universal, generalized, interpersonal kinds of concerns we kept hearing from the clients? Could we video tape the client and the counselor in this generalized kind of fear situation? Could we simulate the nightmare? Could we simulate the things we're afraid might happen but never do because we never let things get to the point where they have to be tested? So, I got two actors and I had them look straight into the lens of a sixteen millimeter camera and recreate certain kinds of scenes. We had scenes ranging from subtle ones where the actor said, "Well, you're welcome to come with us, of course" with a little smile which gives you just enough of "I don't really want you there" all the way to very obvious, blatant situations. Or a person being seductive from a subtle, "Gee, you're a nice person" all the way through to "I've just got to have you right now," and many others. Our first question was, "Would people fall for it? Could we make it real?" But we tried it and we found people talking back. We then began video taping the subject as he watched the simulation, one camera on the subject and the other camera on the film. Then the person sat down and looked at himself as he looked when the actor was telling him he was going to beat him up or whatever. And if you want a stimulant in therapy to help someone start talking about what happens to him in certain kinds of situations, this is tremendously potent.

It also occurred to us that we could make special simulations for special purposes. We could take teachers and, instead of helping them with their generalized interpersonal relationships, move in depth in relationship to their fears about children in classroom situations.

For instance, we made some films of black and white teenagers looking up at teachers and saying the kinds of things that usually drive teachers up the wall. "Okay, if you're big enough to sit me down, sit me down." "Gee, I tried to get you to like me but you just don't like me." It's very effective as a stimulant for discussion with teachers about their fears and what they would do if this happened to them. One of the things that comes up with teachers very frequently is that, before they see the video playback, they say, "Well, yeah, that kid got to me, but one thing's for sure, I'm not going to let him know it." And then they look at the video playback and they see the way they looked and they say, "It's written all over my face. And, of course, any kid could see that he got to me." This is, of course one of the things that we so much want supervisors to learn--to stop trying to hide so much because you aren't doing it anyway. The kids read you and they know what's going on so what you're modeling is that you were affected but you're not going to show it. So you are really reinforcing lying behavior and teaching them how to lie. Maybe the more appropriate thing is to let them know when they got to you and when they didn't.

If we were going to redo our counselor education sequence now I would introduce simulation and feedback very, very early. I would probably introduce it shortly after they've gone through the business of rating other people's emotions, maybe after the first actual session. And I would use more simulations. All I have now are films of adults. But one day I hope to be able to make new films of clients doing the kinds of things which are nightmares for counselors. We have one

complete role of the adults you saw in the film. I want to point out that what I'm spending a lot of time on now is one tool which will serve one or two functions. This is not a total complete treatment. This is one tool to be used at some point where it's appropriate in therapy sequence, along with others. I don't want to blow it out of proportion but it is such an exciting tool that I want to share my excitement.

NOTE: Dr. Kagan spoke informally and utilized much audience participation. This article has been edited from the audio tape of his presentation with audience participation eliminated.

## Federal Support for Speech and Hearing

Mary Ann Clark, M.A.

I am pleased to be invited to represent the agency which is funding this important institute. The U. S. Office of Education is interested in supervision because we are aware of the many areas of need which can be affected by the provision of good supervision.

The clinical staff which has the supervisor's encouragement to evaluate and to improve the therapy services offered has a dynamic program in operation. The students in training who have the support and the clinical model of an insightful supervisor are certain to provide better help for children and are more likely to choose a career in the field. The part time employees, the volunteer assistants and the supportive personnel find their roles more clear, their "mesh" with the basic professional staff more simple and their enjoyment increased with the help of a competent supervisor. The school with a good speech and hearing supervisor has a link with the rest of the school system and with other parts of the professional community which benefits all parties.

The informed supervisor can advise his staff on potential resources for program development. One of many such resources is the Federal support for education of handicapped children. I would like to discuss the work of the Bureau of Education for the Handicapped and help you perhaps to discover some new possibilities for your own clinical programs.

Federal support for speech and hearing has traditionally been concentrated in the Department of Health, Education and Welfare (HEW). A variety of programs are supported by the National Institutes of Health

including the National Institute of Child Health and Human Development, the National Institute of Dental Research and the National Institute of Neurological Diseases and Stroke. The Office of Maternal and Child Health also has some training and service support. Until recently, the largest single program and perhaps the best known to students in speech and hearing was the support available through Social and Rehabilitation Services. A more recent addition to the Federal scene are the programs supported by the U. S. Office of Education, which I represent.

In 1967 Congress created the Bureau of Education for the Handicapped to consolidate in one Bureau all aid for the education of handicapped children. Since that time, we have become the major Federal support for teacher training, research and service for handicapped children, including the speech and hearing handicapped. The Elementary and Secondary Education Act, Public Law 91-230, provides in Title VI for the education of the handicapped.

The Bureau is headed by an Associate Commissioner of Education. His immediate staff includes the people responsible for program planning and evaluation, for the administration of the total Bureau, for its relationship with other parts of the Office of Education and the Department of Health, Education and Welfare, and also for the dissemination of information and distribution of literature. The full Bureau has the services of the National Advisory Committee on Handicapped Children which is made up of non-government experts and laymen who advise on the administration and operation of programs and who make recommendations for the improvement of Bureau programs in an annual report to Congress.

Each of the Bureau's three divisions--Educational Services, Research and Training Programs has programs of benefit to the speech and hearing handicapped. Let me describe the Division of Educational Services which contains the largest number of activities which might affect your clinical programs. This Division provides assistance to the States for the initiation, expansion and improvement of education for handicapped children, under Title VI-B and Title I. Some of the data reported on these programs by the various State departments of education are of interest to us. I quote these statistics from Better Education for Handicapped Children, Annual Report Fiscal Year, 1969, published by the Government Printing Office, Office of Education, OE-35097. The total expenditure under Title VI for Fiscal Year 1969 was $24.5 million. Of that amount the States reported spending about $3.3 million for the speech impaired and another $2.7 million for the deaf and hard of hearing. That total of $6 million ranks second to the amount spent for the mentally retarded, which came to $9 million in 1969. In the previous year, 1968, the States reported a total of only $1.9 million in the speech, hearing and deaf areas. It is of interest to note further that the State departments report only half of their speech impaired children who are receiving services. They further estimate that about 22,000 additional personnel would be required to serve the speech and hearing impaired.

Under Title III of the Elementary and Secondary Act, provision is made for the development of supplementary educational centers and services. Beginning in 1969, the legislation required that each State devote 15% of its money to special programs benefitting the handicapped.

Although State reports do not categorize expenditures by handicap, our office estimates that approximately $17 million in Title III funds were earmarked for the handicapped in 1970 and that 1/% of that amount, about $2.6 million, was spent in speech and hearing activities.

The basic portion of the Service program, Titles I, III, and VI-B, are formula grants to the States to be used according to plans developed at the State level. Two other programs in the Division address themselves to specific target groups--the deaf-blind and the young handicapped. Grants in the Early Education Assistance Program and the Deaf-Blind program are available to private non-profit agencies as well as to public agencies.

The Early Education activity is designed to encourage the development of model centers for the early education of handicapped children. With the $3 million budget for 1971, 47 projects have been funded. Some of these projects concentrate their services on the handicapped child in the inner-city, others in rural areas, still others in community centers.

As a profession, we are well aware of the importance of early intervention. We have long been in the business of caring for children from early childhood while general education has more traditionally been considered to begin at age five or six. The present interest in extending programs down to include younger children may provide an opportunity for this profession to share the leadership in improving educational opportunities for young children. We have known for years about the need for parent counseling in the child's early years when there is a problem of stuttering or language delay. We also know the urgency of

early identification and assistance to children with severe hearing problems and the importance of early intervention for children with cleft palates. We are further aware that the presenting complaint of poor speech and language is often the first clue to problems of mental retardation, hearing impairment and other neurological disorders. As we become more sophisticated about the diagnosis of important language differences and as we develop effective therapies, we will have even more to contribute to these early education programs.

One feature of the early education program is the importance placed on parent participation. We are living in a time when consumers, parents among them, see some value in speaking out, in getting involved, in helping to shape the programs their children receive. The benefits from increased parent involvement should be reaped by the children, their parents and the education center.

Another program now in its second year is the Deaf-Blind Regional Centers which were developed in response to the children affected by the 1964-65 rubella epidemic. This year, 10 centers for deaf-blind children will be funded to provide diagnostic services for educational placement in adjustment programs, counseling programs for parents, services to the teachers and other personnel. At the present time, this program is funded at $2 million and it is scheduled for increasing emphasis in the coming years. A major effort in this program is the identification of all deaf-blind children so that better services can be provided them.

The Research Division carries another critical aspect of our mission to better educate the handicapped. This $14 million program includes

a number of activities in the speech and hearing area. One of these is Dr. Daniel Boone's video tape self-confrontation project which you heard him discuss yesterday.

Another project funded under the Research Division is the demonstration grant to the American Speech and Hearing Association from which all of you have probably benefited. This grant allowed the employment of two new associate secretaries, one in the area of school-clinic affairs and another in urban affairs. The successful workshops conducted throughout the country last spring for public school clinicians were supported by this grant. The estimate of total expenditures in this Division in speech and hearing for Fiscal Year 1970 is about $1.3 million.

The third program unit is the Division of Training Programs. There, we have an operation very closely involved with the training of speech and hearing personnel since 1964. While other agencies also support training in speech and hearing, the Bureau of Education for the Handicapped is the one with the mandate to train speech and hearing personnel for careers in the schools.

The Federal Government first authorized money to train teachers for the mentally retarded in 1958, under Public Law 85-926. In 1961, a program to prepare teachers of the deaf was added, and in 1963 the Law was expanded to include the preparation of professional personnel in all areas of the handicapped; that is, children who are "mentally retarded, hard of hearing, deaf, speech impaired, visually handicapped, seriously emotionally disturbed, crippled, or other health impaired, who by reason thereof require special education and related services."

Training grants are made to colleges and universities for the support of students, faculty and the training institution involved with preparing speech and hearing personnel. I think the Office of Education can be credited with directing the attention of a number of training institutions to the importance of the school setting as a critical environment for speech, hearing and language therapy. Among other items, the guidelines for this support require that the training center provide practicum in the schools, that they include somewhere in their curricula an orientation to school programs, and that the faculty include people who have had clinical experience in the schools.

Recently we asked our training consultants to think about changes they have seen in training as reflected in the applications they had just completed reviewing. These consultants are professionals outside the Government who work in colleges, in clinical settings and in State agencies. They came up with some very interesting observations. One of the issues they discussed was the relationship of the clinical trainers with the school clinicians. Let me quote from their comments.

> Changes in clinical training are apparent. In the not-too-distant past, the campus clinic was the practicum site. The Division of Training Programs Panel feels strongly that a speech clinician cannot be adequately trained without experience with a variety of communicatively handicapped people in a variety of work settings. Applications for funding now reflect that training programs almost universally are utilizing as practicum settings school facilities, hospital settings, community speech and hearing centers, in addition to campus clinics. College and university training programs have established better relationships with the people in the schools and vice versa. Historically, a hiatus has existed between university training programs on the one hand and school service programs on the other. Despite the fact that the major employment opportunity of speech and hearing programs was in the schools, typical academic faculties made little effort to investigate what actually went on in school therapy situations, to evaluate the success of their students in these

> programs, or to seriously react to the suggestions by school administrators as to needed modifications in the training of school clinicians. Until recently this gap has been growing. It's being increasingly recognized by training personnel that the American school system is the natural environment in which to do speech therapy. The extension of pre-school programs downward in age and the upward extension of vocational and adult education are minimizing the age limitations of the schools. Moreover, the quality of school programs has materially increased in recent years. This change in quality is reflected in reduction of caseloads, in severity of caseloads, in quality of supervision and data keeping, and so forth. As a consequence, many training programs of quality are not specifically preparing their clinicians for work in schools. As a result of this change, active cooperation is beginning to take place between training programs and school service programs and the cooperation is evident in such factors as joint appointments, actual observations by university people in school settings, joint staffings, and systematic investigation of the effectiveness of training programs for a school situation. 1/

One of the other matters very carefully reviewed in the applications from the universities is the matter of supervision, not only in the university clinic, but in the schools. The Panel is very concerned about what happens out there. You know how meager our training for work in the schools has been. The "practicum" was sometimes a matter of providing services to a school in the neighborhood which couldn't afford or didn't desire a clinician on its own payroll. What we were really doing was putting an untrained student out into a situation where he had little direct supervision and limited assistance from a graduate student more concerned with his own academic work than with the supervision he was assigned to earn his living. In a real sense, the student was responsible to the local school for providing the work of a professional clinician. It is surprising that people "prepared" in this haphazard fashion ever chose careers in the schools.

1/ Statement of USOE Speech and Hearing Review Panel, January 1969

Other questions regarding supervision we consider very important are: "What local school clinician will be supervising when University X sends students to this school?" "What university staff person will work with the student clinician and the school clinician?" We want to know that the colleges are providing some direct supervision for students during the school practicum. We believe that these supervision concerns will help to make the training for work in the schools somewhat more organized and more fruitful.

In addition to the direct grants to colleges and universities, our training legislation also includes a provision for the State departments of education. Twenty percent of the training money is allocated to State departments of education so that they may make some decisions about what kind of training they feel is needed in their own States. The money is distributed on a formula basis and offers an opportunity for people at the State level to have some in-put on the kinds of institutes best suited to the needs of their State personnel, the fellowship or summer session provisions they need. You can see the importance of making known to your State department personnel your specific training needs. Last year, 1969-'70, the amount of money spent for training at the State level in speech and hearing under this program was about $730,000. This year, 19 states are planning institutes in speech and hearing. Fifty-three other institutes will be held under the category called "inter-related," and many of those will include speech, hearing and language concerns.

What are the implications of these facts for the speech and hearing profession? What can we expect for the future?

We can expect a continued demand for more trained specialists to work in the schools. We can expect greater involvement of the professionals with the State departments of education. We can expect more parent participation in requesting, developing and using service programs.

Some increases in training money probably will occur, but perhaps not in the traditional form. Looking at the data from all the States, our best information now is that only about 40% of all handicapped children are receiving services. There continues to be a scarcity of personnel to serve them, and we will see more attempts at other kinds of training, probably some in the area of supportive personnel. We also need to find ways to train full professionals differently. Training centers will be asked to tell us how they can best train a given number of students and the plans developed at University A may well be different from those developed at University B. We have a small special projects program in our training division whose purpose is to encourage people to think about new ways of getting the same product or new ways of getting a new product to do the old job. It is a very small investment at the moment, but if we begin to get some promising results there you may see increasing emphasis on special projects.

As more decisions are made and as more money is available at the State and local levels, more people will have the opportunity to effect the priorities for their localities. Thus it is critical for the speech and hearing people to find a voice for their concerns, both within the local programs and with the legislators who have the ability to expand

support for the handicapped. We have to be involved with the setting of priorities. We have to be effective in broadcasting those programs that work well. We have to assess our needs for new assistance and to make them known. We have to be ready with some good projects and programs to demonstrate that we are well able to improve the lot of the handicapped children with speech, hearing, and language problems. That after all is the business of all of us--to effect changes that make for better communication for the handicapped.

## Program-Planning-Evaluation

Stan Dublinske, M.A.

One of the most important roles of the supervisor of a speech and hearing program in the schools is to insure program continuity and effectiveness. Another dimension that we can add to this is accountability. All of us are aware of the push by taxpayers for accountability in the educational process. They are concerned with the amount of money placed in the educational coffers and are demanding that it be spent in terms of:

1. Efficiency: Am I getting the most learning experience in the least amount of time for the least amount of money for my child?
2. Effectiveness: Is the money I put into learning experience the most effective use of my money to achieve that educational objective?
3. Economy: Are there alternative methods of programming and administrating that are less expensive than the present methods?

As supervisors or clinicians we must get involved in the "Three E's" actively and soon. In the schools we find that we are having to justify our positions more and more frequently. In many areas special service personnel are considered a "frill" and are the first to go when a large budget cut must take place. The "frill element" becomes quite evident when we take a look at the commitment the schools have made to speech, language and hearing services. Do we get the best possible rooms to work in? Are we allowed to schedule our cases on a basis similar to other

NOTE: This topic was not included in the pre-planning of the Conference. However, because of the current interest, Mr. Dublinske presented this information at an evening session. Mr. Dublinske is Consultant, Clinical Speech Services, Division of Special Education, Iowa Department of Public Instruction.

educational services and activities? Do we get the quietist rooms for hearing testing? Do we get full cooperation from administrators and teachers? Unfortunately, in many cases the answer to these questions is, "No." If we are going to insure that our services become an integral part of the educational system, we are going to have to develop a system of accountability which will generate data that shows that we do indeed provide a valuable service to the total educational process.

One of the problems in discussing accountability with clinicians is that, as soon as you mention the concept of measurable objectives or performance criteria, it brings to the surface the "CAN'TBEDONEISM SYNDROME." For some unknown reason we, as clinicians, feel that we can't measure the job we are doing in terms of effectiveness or be held accountable for the job we are not doing. I think that we, as clinicians, must develop our own program goals and objectives and set our own performance criteria before others do it for us.

Just what is accountability? Accountability is defined simply as knowing: (1) What you are going to do, (2) When is it going to be done, (3) How you will know when you are there, (4) And the cost involved in getting there.

The system that is involved in achieving accountability can be called Program-Planning and Evaluation. Many systems have been developed to achieve management by objectives and all revolve around identifying needs, developing goals, writing measurable objectives, and putting a cost factor on achieving the various goals. Each state or unit may have its own term for the system they use.

The steps involved in developing a PPE system are as follows:

1. Develop a goal structure based on desired program functions within which all personnel may develop objectives. The program functions that should be included are program development, staff development, budget, program evaluation, public relations, liaison, instructional services, in-service, research, transportation, facilities, recruitment, curriculum development, equipment and materials, identification, and others.

2. The next step is to identify and verify needs. The staff may then begin to write measurable objectives.

3. The most important step in PPE is in developing objectives. In PPE we discuss two types of objectives: Program Objectives and Instructional Objectives. Any objective that does not deal directly with children is considered a program objective. Program objectives deal specifically with the teacher-child relationship and are used to evaluate effectiveness of this particular phase of the program (direct instruction). Instructional objectives must be developed on an individual basis; program objectives may be developed as a staff function.

The following are examples of program objectives:

A. By June 1, 1971, each clinician will have held a minimum of ten direct contact conferences with the instructor of each student in the caseload to discuss the child's progress and give the instructor a minimum of three suggestions for classroom activities that can be used to improve the child's speech and language skills in the classroom. A conference report will be submitted to the supervisor and classroom teacher indicating the content of the conference, the suggestions made and the number of suggestions carried out to completion from the previous month. Report to be submitted within five days after completion of the conference.

B. By September 30, 1971, each clinician will have selected a caseload of not more than 50 students. A list of cases selected and the indicated problem will be submitted to the classroom instructor, building principal, and program supervisor five days prior to the first day of service.

The following are examples of instructional (behavioral) objectives:

A. After 15 hours of direct contact service with the clinician, John X will produce the correct /r/ with 98% response accuracy in four 30 minute sessions as recorded in 40 minutes of directed oral reading, 40 minutes of structured verbal response, and 40 minutes of general conversation activities.

B. After three hours of direct contact service with the clinician John X will have increased his response accuracy ratio on the /s/ by 30% as indicated on a transcription of audio recordings of session one and session 12.

1. The final step in PPE is developing the program budget. The final budget can be developed after the objectives have been written and a specific amount of time is allocated for each objective. This is accomplished by arriving at a basic support figure for the personnel involved and multiplying it by the number of days for each objective. Once the cost of each objective has been computed, objectives can be totaled vertically to obtain the cost of completing a particular goal or the total program budget. The total cost of the program budget may be much higher than the traditional line item budget that has been allowed in the past. It is then the responsibility of the financial decision makers to cut out specific programs and components until they arrive at a cost of education that they feel is permissible. In doing this, it must be realized that cutting resources also reduces the impact the program will have on the education of students in their unit.

As a supervisor you can develop a program system that revolves around six basic program components: (1) Identification (2) Remediation (3) Referral (4) Consultative (5) Administrative, and (6) Research Development Services. Within these components you can indicate how many hours of service a child gets, how many parent conferences will be made, how many carry-over suggestions made, professional meetings attended, number of cases seen, office time, research projects developed, etc. To measure the effectiveness of the clinician-client relationship, which is really what accountability is all about, we must develop instructional objectives or behavioral objectives which tell us where the child is now, where we want him to be at the end of a specified time period, the criteria for indicating achievement and the evaluation procedures used to measure effectiveness.

As an example of the difference between most traditional programs and the programs that use the Program Planning Evaluation principles, I would like to share with you a report that could pass between a supervisor and a director of special education. The director has asked that the supervisor submit a monthly progress report for October. The first responses come from the supervisor who is not using the program planning evaluation principles.

1. We had 200 cases scheduled during October, 1970.
2. We are trying to get teachers more involved in the carry-over process with children in their class.
3. We are continuing work on the language development manual for special class teachers of the educable mentally handicapped.
4. We dismissed 20 cases during October, 1970.
5. We had an in-service meeting on Behavior Modification Principles Applied to Articulation Problems.

These responses from the traditional supervisor can be compared with the responses of the supervisor who is utilizing the Program Planning Evaluation principles.

1. All clinicians scheduled a maximum of 20 cases seen four times per week on an Intensive Cycle Schedule for 30 minute sessions. Each child received a minimum of four hours of direct contact service during October. A total of 200 cases were scheduled for a minimum of 800 hours of direct service.
2. Each clinician held a direct contact conference with each client's teacher and discussed the child's progress and gave the teacher three more suggestions for working with the child's speech in the classroom. Of the 1,000 suggestions given to teachers by the clinicians in September, 87% were carried out. This is an increase of 17% over the September report.
3. We have two chapters out of ten completed in the booklet "Language Development Activities for the EMH." We spent a total of 16 staff hours thus far and plan to be done with the manual and have it ready for final copy in 70 more hours.

4. We increased the response accuracy ratios of 100 cases by 30-50% over September ratios. We increased the RAR by 50% or more in 80 cases and we dismissed 20 cases who were responding with 98% accuracy in four consecutive sessions consisting of directed reading, structured verbal response and general conversation activities. These 20 cases will be followed-up four more times during the rest of the year to check for regression.

5. We held an in-service meeting on Behavior Modification Principles Applied to Articulation Problems with all clinicians in attendance. Eighty-seven percent of the meeting objectives were met and 100% of the clinicians agreed to conduct a behavior modification program with one or more students and submit the results to me by December 1, 1970.

If you were the administrator who was being held responsible for the total effectiveness of the program and had to request money from the school board to hire additional speech and hearing personnel or expand programs, which report would you want to get?

The important thing to remember in planning is to make sure objectives are measurable and not broad statements of intent or goals. The supervisor is the one who is directly responsible for the program, and considering the fact that we can no longer accept that some clients receive service for two to five years and still are not dismissed, I think it is important that we look at some alternative methods of programming which will have an impact on the service provided to children and the progress they make.

A problem we have had in speech and hearing in reporting program effectiveness is that everyone wants to blame someone else for the ineffectiveness found. Clinicians blame universities, parents blame the school, teachers blame it on poor materials. Nobody wants to be held accountable. What we need is a judge to make a decision. I think we have found the judge in the measurable objective. Either the objective is met or it isn't, and nobody is to blame. However, if we are to

be successful in attaining our objectives, we are going to have to investigate program planning evaluation principles and develop programs based on concern for changing behavior in children.

## Training of Supervisors of Speech and Hearing Programs in the Schools

PANEL DISCUSSION

Moderator--Dr. Kennon Shank

One member of our group has just provided us with some bubble gum and I find on the wrapper of mine what may be a definition of a supervisor. A boy is saying, "I'm going to the pet shop to sell my dog." The man answers, "Sorry, Pesty, I can't buy that mutt," to which the boy replies, "He's not a mutt. He's four different kinds of a thoroughbred."

In beginning this panel discussion on training, I'd like to make two or three comments. I think it's important that we start with the assumption that speech pathology and audiology is a professional field in its own right, not a part of some other field. Secondly, I believe we need to assume that, as a professional field, we have developed some training standards, guidelines by which we train our people. Thirdly, it's important that we accept the fact that we, as a profession, know more about what we do than anyone else does. The standards we have set up for our profession are a good base from which to operate. The question, then, to which we want to address ourselves is: When and how do we train a supervisor in this professional field? I'm going to ask Ted to start us off today. He has some ideas about the skills which should be possessed by people who are going to be supervisors and how they should be trained.

Dr. Ted Peters, University of Wisconsin

As I've been sitting through this Conference, I have found that I have grouped much of what has been said into two categories:

(1) "supervision," that is supervision of the actual therapy process itself; and (2) "administrative," or in other words activities, like budget making, program planning, interaction with different department heads, etc.

I think that "supervision" would be very similar from one environmental setting to another, whether it's in a public school, a clinic or a training program. The only difference may be in the level of sophistication of the person being supervised. So let me begin by talking about "supervision," what experiences and skills I think supervisors should have, and where the training programs could get involved in their training. First of all, I believe very strongly that a supervisor needs to be a skilled clinician. Although, I know there's no magic in a Master's degree, I do assume that a supervisor should have at least a Master's degree and a few years of experience. And, since we're talking about supervisors in the schools, I would like to see at least some of this experience take place within the schools, dealing with that age group, the kind of problems that are confronted in the school, etc.

Where, then does the training of a supervisor come in? I believe that this training should be post-Masters training--perhaps somewhere during those first two or three years following the Master's degree. I have no definite opinion whether this is done part-time, during a summer program or by going back to school full-time to get an advanced degree, but I do think that the training of a supervisor should include some background from the following three areas.

First, I can envision seminars or courses that would deal with certain theories and methods involved in the supervision of therapy, for example, the information brought to this Conference by Boone and Diedrich. I believe there should also be a practicum in conjunction with these courses. The practicum would involve actual supervision of clinicians, possibly students in training, with frequent meetings with an experienced supervisor to discuss problems and techniques related to this supervision.

A second skill area that I see the training programs providing is related to the interaction of human beings. This ability, I believe, is one of the most important dimensions of a good supervisor. When I look at the problems I've had in supervision and what I've seen others have, it seems to me that they have arisen out of an inability to interact effectively with the other person. Some people may be born with the innate ability to interact with people, but I think it can also be trained. Whether we use sensitivity groups, encounter groups, therapy groups, individual counseling or whatever, it is important that we have a way to develop the ability of supervisors to understand themselves and others and to learn to interact effectively with others. Let me draw from my own experience. I had a minor in guidance and counseling and part of our work required involvement in a therapy group, like a sensitivity group. Besides dealing with our own problems in this group, we also dealt with the therapy that we were doing at that time in the counseling center. Thus, we not only were helped personally, we were also helped in our clinical counseling skills. Some of the skills I

find most helpful for me, in dealing with students, and in supervising, come from the guidance and counseling area. I believe we need more of this in the speech and hearing field.

In the third area, and it would not have the emphasis of the first two, I see training programs providing supervisors with some clinical research skills, so that they can systematically study and analyze the problems within their own clinical programs.

In the area of "administration," I would think here again some of the information and skills would be comparable in all employment environments. I believe much useful knowledge, such as that presented by Reitz and Mee at this Conference, could be obtained from course work in such fields as organizational theory, business management, etc. There may, however, be some administrative problems unique to the schools. Therefore, some course work in education policies or educational administration would be beneficial to help supervisors understand how schools are organized and financed and where our programs fit into the total educational picture.

This then, concludes my current thoughts on when and how we train people for the important role of supervisors of speech and hearing programs in the schools.

Moderator - Mary Wood is going to talk to us about how the University of Texas trains supervisors.

Miss Mary Wood, University of Texas

For several years, at the University of Texas, part of our graduate program included a weekly staff meeting on training in supervision. The graduate students who participated in such staff meetings were advanced.

In the early stages of the program, students who had in excess of 100 cli.ical hours were invited; more recently we have allowed only those who have 200 clinical hours to participate. Student supervisors were assigned to a team of student clinicians and the whole unit of student clinician-student supervisor was supervised by a staff member. After several years of experimenting with this, we decided that it was possible to teach some of the aspects of supervision. From this experience has evolved a graduate course in supervision. Dr. Lear Ashmore's book is used in the course. When no graduate course is offered we still have the staff meetings for selected students in which we discuss supervision. Student supervisors bring to the class or the meeting the problems they are having as supervisors and these are discussed.

In order to illustrate graphically to the students all the component parts of supervision we use what we call a supervision triangle. The middle of the triangle is the supervisor; one side of the triangle is the employment facility; one side the supervisees; the baseline the duties of the supervisor. The graduate course, the staff meetings and Dr. Ashmore's book are all divided into three major sections--administration, instruction and clinical supervision. The emphasis in teaching in these areas is on the following: Administration includes personnel problems, scheduling problems, public relations, working conditions, and leadership skills. Instruction includes such topics as the role of learning theory in the supervisor-clinician relationship, listening skills, technical skills, the role of personal bias in supervision, observation and description of behavior, how to give constructive criticism, in-service training, and conducting staff meetings.

Our biggest problem is how to provide a practicum experience. In the graduate course, and more recently in staff meetings, we have the students divided into several groups. Each group has an equal number of student administrators and student supervisors. As yet, we haven't worked out the personnel problems involved in giving each student an opportunity as both administrator and supervisor so it is very rare for one student to have the practicum in both areas. The student-supervisors are assigned to less experienced students to "supervise." The team of student clinicians with a student-supervisor is supervised by a staff member. Student supervisors are required to observe their "supervisees" at least once a week and use some form of observation scale. They also have conferences every few weeks with their staff supervisor to discuss all aspects of the student clinician-student supervisor-client relationship. In these conferences they discuss such topics as what the students are learning, what the student thinks about the experience, the problems they are having in communicating, their use of observation forms and the therapy being done by the student clinician.

Student supervisors have some problems that can't be brought up in the unit conference with the student clinicians because the student supervisors have a hard time learning how to deal with personal conflict. For one thing, they are not too much older than the student clinicians they're supervising and they have a very difficult time providing constructive criticism. So some of these problems have to be worked out in the staff meetings or in the class.

The student administrators in each group are assigned to other staff supervisors for administrative work which includes a variety of assignments. These assignments include such activities as intake referrals, learning the forms and filing systems, helping schedule for evaluation and therapy, helping design and execute parent-education programs, planning the non-credit staff meetings that our students are required to attend every week, equipment maintenance and record keeping. They're required to come up with some administration innovations, either for our clinical program or for a public school or agency program they've visited. Sometimes they are given projects. The groups meet together independently of each other and independently of the class or the staff meeting. They share their problems and student administrators frequently undertake projects such as administrative innovations for our program, case-study problem solving, designing observation scales, designing evaluation scales for student clinicians and public relations problems.

One of the side effects of this program in student supervision is that it seems to provide some level of understanding and communication between the students who have had the course and the staff supervisors. It's as though the students never completely return to the role of student.

Moderator - Let's move over to Bette Spriestersbach who is going to talk about what she calls mini-research activity, in which she has been engaged in Iowa.

Mrs. Bette Spriestersbach, University of Iowa

The project I'm going to talk about is a planning project related more to student practicum in various field settings than it is to training of supervisors. However, there may be some comparisons to be made. The concept of practicum in field settings is not a new one around the country, as you know. However, we wanted to find out if we can do anything within the model of the fiel etting that we can't do on campus.

When I began, I sent questionnaires to the directors of ETB certified training programs in the country. When I asked why they used the field setting for practicum, the answer was usually, "Because we have to enable our students to get clinical practice with live bodies of various kinds." I realized how lucky we have been at Iowa to have so many practicum facilities close at hand. We have, for instance, major medical facilities which include speech and hearing services in otolaryngology and pediatrics, a hospital school for severely handicapped children, an EMR program, a V.A. facility and the public schools. So we have not had to send students out of town to get clock hours. However, all of these settings are basically training institutions except for public schools and the V.A. A similar philosophy pervades all of them so we wondered if these places offered the breadth of experience needed.

In Iowa, about five years ago the Governor issued a directive saying that all services provided by the State, from Motor Vehicles to Social Welfare, must move to a delivery of services on a regional basis with regional centers throughout the State. The centers for regional educational services are called Regional Education Service

Agencies. These are agencies which take in all services other than regular classes. We were interested in knowing whether it is better for the student clinician to go out to a service setting of this type for his practicum or if it is the therapy he does that is important, regardless of the setting. Is it important for him to experience the "Gestalt" of the whole setting? Are there things that are so different in various service agencies that the students need to experience them? Would this kind of experience put what happens in the therapy room into a kind of perspective in terms of delivering service in various agencies?

We have been able to have a trial run on this. We are not going to build a prototype at this point in time because of the slow pace of development of regional programs. We were able, within the framework of the public schools practicum, to put two students in the traditional program within the Iowa City system as controls. They went two afternoons or two mornings a week throughout the semester. Of the rest of the group, four were placed in a seven week block in systems which happen to be within driving distance but were regional programs. They went all day and they did nothing else except attend a group meeting with other students doing practicum on campus. They had no didactic course commitments or other therapy commitments, so they were free to give their total effort to the practicum. The controls had classes on campus. We were interested in seeing if there was a difference in what the students got from these two kinds of experience.

The supervising clinicians in the regional programs had never supervised students before. I should say, parenthetically, that I had spent about a year trying to learn what I could about the supervisory

process as it applies to activities that presumably help a student trainee become a better clinician. So we invited the supervising clinicians in for an all day talk-session where we talked about the supervision process. We had them do a little practice and talk to each other about what they were doing, right or wrong; how it could be changed and how to present a good reason for what they did as they demonstrated. This proved to be a very difficult thing for them to do and it obviously takes practice because the second time they did this little experiment they were better at it. They were more comfortable and the students did seem to get more from it. At the end of the two block periods we talked together again about the sorts of experiences the supervisor had within the block. We talked about communication, logistics and so on. Then we asked them to suggest structural changes of the experience within terms of what could be done in their programs.

We asked the students to keep a diary plus other more formal reports and this turned out to be the most useful thing. We asked all of them to do this, including the ones doing the traditional kind of practicum in a service program. One thing that showed up was that, in the traditional experience, the students never talked to themselves in their diaries about anything beyond what the children were doing in therapy. Occasionally there would be a comment about a conference in which they had been involved but they never really indicated that there was anything out there beyond therapy. The ones in the field setting were quite a contrast. At the first, of course, they were terribly self-concerned. "How am I doing?" "This supervisor isn't so

great because I keep asking her how I'm doing and she won't tell me. She talks about what we can do with Johnny or how we can handle this group a little differently," instead of feeding the ego. But they tended to stop talking about this kind of thing and they became more involved in a classroom teacher hassle out in School A and the effect it was having on the climate within which the kids and the teachers were operating. They became concerned with the problems of dealing 'th parents in a high socioeconomic school or with problems with administrators. Or, "If I were running this program, this is how I would like to set it up." So they were able to attend to things that were important about the whole service center.

We were able, through a couple of conferences both in the middle and at the end with students and supervisors, to get some information about ways in which students ought to be better. What we don't know, of course, is whether this kind of practicum can be done in any kind of a service setting and have generalization from it to another setting. And we really won't know, until lots more students can try it, if it has value or if it allows clinicians to begin work a little better oriented to the setting. The other question I would like to have answered is whether this gives them a head start on perceiving the things involved in the supervisor's role. This has a number of implications for training of supervisors.

Discussion Period

Moderator -

We've had some suggestions based on our biases, on a course and practicum which departs somewhat from the total training program and a "mini-research" project which may be relevant to the training of supervisors. We know that sometime-somewhere universities are going to assume or be asked to assume responsibility for training supervisors. So we'd like to hear what experiences you have had or wish you had been able to have had before you became a supervisor.

Question: A question for Mary Wood. If you were to get a request for a supervisor would you recommend one of the supervision trainees who has just finished a Master's degree?

Answer (Wood): No. I do not believe that a course in supervision is going to teach you how to supervise anymore than a course in therapy is going to teach you how to do therapy. I think the student supervisors who have had our course ought to have experience as a clinician in a working situation before they attempt to function as supervisors.

Moderator: So, you do not train a supervisor. You expose your students in training to a course?

Answer (Wood): That's exactly right.

Question: I'd like to ask Mary Wood about the effect on the less experienced supervisee of relatively inexperienced supervisors and also on the clients who are receiving therapy. I have some concern here and that is why I would favor putting this kind of supervision training later on in the person's career.

Answer (Wood): It has been our experience that the young student clinicians do not suffer. In fact, they usually report great profit from the experience. We try to guard against any harm to our clients by closely supervising the team. Occasionally there are complaints from the young student clinicians about their student supervisors but 90% of the complaints have been of a personal nature rather than complaints based on the inexperience of the student supervisor. I think one of the advantages is that the student clinicians are required to plan and account for everything they do to the student supervisor. The student supervisor sometimes has more time for conferences with all students than the staff supervisors do.

Question: Have you considered using your plan of training supervisors in either a workshop or a summer program for people in the field? It would seem to me that clinicians with a year or two of experience might be most receptive to this approach.

Comment (from audience): I think this would be good. There is a point at which a clinician who has been working for a time wants advancement. Most educational settings are offering salary for credit beyond the Master's degree. Some states have requirements for certification as supervisors or administrators which could be met with some specialized training such as this. In addition, however, they need information about state laws and state certification. And we can also gain much from other areas, particularly business management.

Comment: Another point we need to consider is that there are different levels of supervision. You have state people who need certain skills at the overall consultant level; in schools now you have directors, coordinators, administrative assistants, supervisors and resource personnel in programs. So, in talking about administration and supervision in the schools, you have to look at the way schools are organized and current trends all over the country because these people are going to go where the opportunities are.

Comment: In addition to the on-campus course work and practicum, it might be advisable to assign people to a state department for six weeks or so for a kind of internship. Or they could be assigned to a good supervisor who is working in a school program to just see the many activities of a supervisor.

Comment: I think it's very hard for anyone when they are first appointed as a supervisor or administrator to "deal with the multi-crisis" types of situations that a supervisor deals with from minute to minute, the tremendous relationships you have with professional groups, the contacts with the public, etc. How do you budget your time in such a way that you are able to divide your time between the immediate "brush-fire need" and the longer term activity. At this point, supervisors in many instances are "fire-putter-outers." You must have a tremendous flexibility to switch from one major event to another within a five-minute period. I don't know how you teach this.

Comment: I saw the technique of role-playing used in working out this kind of experience.

Comment: I would certainly say that this Conference is a step in the right direction. I assumed the job as supervisor after basically eight years of experience as a clinician and up to that time I couldn't credit one single hour of course work anywhere related to the specifics of the job. I think the ideas presented here are a good start but perhaps the complexity of the job makes it more appropriate to offer it to a person who has had experience.

Comment: I like the ideal of small groups getting some experience and then coming back and exchanging information. Perhaps there would be a value in a course of this type in the training program at the Master's level, followed by a summer workshop or an in-depth program including some of the activities discussed. What would happen if you took a group of people who wanted to be supervisors or had just been appointed to the job and, in a seminar setting, posed some structured problems drawn from people who are supervisors and let them work through them. Of course, you can't program in all the interruptions and demands but you can certainly do some of the basic things.

Comment: Perhaps an adaptation of micro-teaching would be useful. I think it is also a good idea to get students to work with real on-the-job supervisors, to follow them around and perhaps be involved in making some decisions. I never had any basics in supervision and what I learned I learned from the person who preceded me.

Moderator: Most of the things I hear you talking about are administrative. Are most of you both supervisor and administrator?

Answer (from group): Yes.

Moderator: Or are we talking about training for activities which relate directly to the clinician-client relationship?

Comment: In our group yesterday we put the items that Jean Anderson had listed on her questionnaire about the role of the supervisor into a matrix and we found that practically all of those activities fell into the area of program management. Very little dealt with clients.

Moderator: But one of the most common complaints we hear from students who come back after employment in the schools is, "There was no one to help me." Is helping them the role of the supervisor and do we need to look at this in our training program?

Comment: I think flexibility is one of our major attributes if we're doing a good job. We are supervisors and administrators and coordinators and we are paid for the judgment of knowing what we need to be at a particular time.

Comment: I think in larger programs the responsibility is eventually going to be divided so that we will have an administrator of speech and hearing and a supervisor.

Moderator: But, in giving our attention to a training program, do we have to decide which it is we are training--a supervisor or an administrator?

Comment: I don't think you can divide it anymore than you can say that you train your clinicians to work with voice problems or cleft palate. You're going to have to train initially to cover the multitude of problems we've talked about and then individually that person is going to have to apply that training to fit the situation.

Comment: I agree with this. I really don't think it's possible to separate our various functions. For example, if we make out the assignment of therapists to a school, that's administration. When we go to visit them in the school it may then be supervision. But while we're there we may talk with the principal about some administrative problem or relate to some other profession. Or you may have some particular clinical skill which you demonstrate and then you are a clinician.

Comment: In a course in supervision which I took we were told to think of it as being super-vision--an overall, large picture as opposed to the smaller parts.

Comment: I think all of these kinds of experiences could be put on the graduate level in many courses or many seminars. I can't see one course designed to do all of this. I think the body of knowledge we've been talking about would be helpful to anyone in the field, not just those who would aspire to be a supervisor/administrator.

Comment: Many supervisors that I've talked to seem to spend a lot of time in proposal writing or grant writing. Perhaps that should be part of the body of knowledge.

Comment: One way that we might be able to get some on-the-job training is through some of the title projects where you might choose an outstanding clinician and have him administer and supervise.

Comment: We hope to do this with title projects and to revise the curriculum so that we can give all of our Masters and advanced students some grounding in a supervising-administering type of orientation in some kind of setting outside the university. This will help prepare the person who early elects administration or supervision as a goal and it will provide the practicum experience as well as the course work.

Moderator: We have come to the time where we must terminate this discussion. We apparently are agreed, as a group, that we must give some attention to the training of supervisor/administrators in our field and that it can be done, even though we do not have all the answers at this point. It is gratifying to know that some programs have begun some efforts in this direction.

GROUP DISCUSSIONS

## Group Discussions

Prior to the Conference on Supervision of Speech and Hearing Programs in the Schools, two kinds of communication were received by the Director of the Conference from supervisors in speech and hearing programs throughout the country--applications on which supervisors were asked to indicate their reasons for desiring to attend the Conference and a questionnaire which was sent to supervisors on which they indicated their needs and problems.

From these two communications it was obvious that individuals now working in supervisory roles in speech, language and hearing programs in the schools have common problems, knowledge about these problems which is probably not possessed to any degree by any other group, and a great desire for communication with other individuals in positions similar to their own. It seemed obvious, then, that there would be value in providing opportunities for the participants to exchange information in small group sessions. Such sessions were planned, therefore, to discuss those topics which occurred often on the applications and questionnaires.

Each group session was summarized and, before the close of the conference, chairmen and recorders were responsible for combining all summaries into a consensus statement on each topic which was approved by the entire group. These consensus statements are reported here.

## Topic I - Rationale for Employment of Supervisors in Speech, Language and Hearing Programs

When a school system employs more than one clinician to provide speech, language and hearing services, a certified and experienced professional person in that field should be appointed with the authority to administer, coordinate and supervise the program. The benefits to a speech, language and hearing program of employing such a person would be:

A. To insure quality control of speech, language and hearing services through

   1. Continuing evaluation of the effectiveness of the clinical services.

   2. Continuing professional in-service training of the staff.

   3. Serving as a resource consultant in clinical matters.

   4. Serving as a resource for recruitment and employment procedures.

B. To insure efficient delivery of the speech, language and hearing services through

   1. Developing and coordinating administrative and organizational functions throughout the school system as they relate to the speech, language and hearing program.

   2. Developing and disseminating procedural information (to clinicians, local administrators, teachers and parents).

C. To implement speech, language and hearing services within the philosophy and goals of the total educational system through

   1. Communicating goals of the speech, language and hearing program horizontally and vertically within the staff.

   2. Providing a resource for other professional persons on the educational staff.

D. To stimulate program development and innovation through co-operating with other supervisors and directors in the solution of common problems and to be responsive to the developing needs of school and community.

Due to the highly technical nature of the remediation of problems of the speech, language and hearing handicapped population it is essential that a person employed for this position meet local, state and national certification standards in the field of speech, language and hearing.

## Topic II - The Role of the Supervisor

The major roles of the supervisor are to manage, evaluate and innovate programs for the communicatively handicapped children and youth within the community. At all times the welfare of children with speech, hearing or language disorders is the reason for the supervisor's activities. Through systematic analysis of children's needs and judgment based on specialized knowledge and decision-making procedures, the supervisor develops and maintains quality speech, language and hearing programs. Among the activities in which the supervisor should be involved are: 1.) the selection of personnel, 2.) evaluation of the clinical process, 3.) acquisition of support from service-oriented and financial resources, 4.) responsibility for communication procedures within the school as they relate to the speech, language and hearing impaired, and application and integration of the program into the total educational program. The emphasis on any one facet of the supervisor's responsibilities may be affected by the size of the community, history of the community's speech, language and hearing programs, and the educational commitments of the particular school district.

## Topic III - Characteristics of the Supervisee

THE SUPERVISEE

A profile of an ideal supervisee will include specific professional knowledge and skills as well as positive personal qualities.

PROFESSIONAL KNOWLEDGE AND SKILLS:

- Knowledge and application of skills appropriate to the employment facility and necessary to function clinically, instructionally and administratively as a speech or language pathologist and/or audiologist.
- State Certification in Speech/Language/Hearing and/or The American Speech and Hearing Association's Certificate of Clinical Competence.

PERSONAL QUALITIES:

- Professional commitment, attitudes and motivation to continue to grow professionally.
- Other personal qualities such as flexibility, ability to work independently, creativity, self knowledge/evaluation, responsibility, sensitivity, dependability, and the ability to communicate effectively.

## Topic IV - The Leadership Role of the Supervisor in Innovative Programming

One of the functions of the supervisor of a speech, language and hearing program is to promote and develop innovative programs in the schools which will better meet the needs of children. This role may be facilitated by the following procedures:

1. Have an awareness of trends in general education, including interpretations at the local level.

2. Provide information and expertise to those involved in making educational decisions.

3. Apply problem solving techniques to implement innovative programs.

4. Secure commitment of staff members by utilizing committees (a) to study the problems, (b) to show needs, (c) to give evidence of inadequacies in current program, and (d) to suggest changes and implementations.

5. Utilize resources outside the speech, language and hearing area in the school setting--classroom teachers, psychological service personnel, social workers, reading specialists, health service personnel, and others--to meet the total needs of children.

6. Obtain supplementary professional support for necessary innovations by making use of resources outside the school setting--state and local speech and hearing associations, state universities, and state departments of education.

7. Continue an innovative program long enough to develop valid evaluative criteria, to evaluate its effectiveness, and to retain that which is found useful.

8. Make known the results of innovative programs to the staff of the speech, language and hearing program, administrators, the local community, and interested professional personnel.

Ideas for innovative programs that might be developed:

1. Utilize video tape for: (a) language programs to reach preschool children and their parents, (b) classroom speech and language programming, (c) therapy sessions, (d) parent education, and (3) in-service training.

2. Utilize media such as films, slides, tape recorders, single concept loops, and radio-telephone hook-ups.

3. Upgrade the speech and hearing program by planning and attending professional meetings; by evaluating and choosing different methods of screening, selection, scheduling, and therapy; and by encouraging continuing education of the clinical staff.

4. Make use of university resources to facilitate research based on local needs in the public schools.

Topic V - Effective Relationships With School Administrators

Discussion of the topic of effective relationships with school administrators eventually led each group to conclude that effective relationships are a direct result of effective communication. Therefore, it would appear that this topic really should be entitled Effective Communications With School Administrators.

As communication experts, we are aware that effective communications must be free of as much distortion as possible. Distortion in the communication channel between members of the speech pathology and audiology profession and school administrators does exist.

One reason for this distortion may be the contrasting backgrounds of those involved. Dr. Lowell Rose, a school administrator involved in the 1966 Conference on supervision, clearly indicated why distortion may exist when he stated, "You are specialists, expert in a particular area, and my concern is for the total school program." (Rose, Institute on Supervision of Speech and Hearing Programs in the Public Schools, 1966.) Because we are trying to effectively execute our basic responsibilities, we tend to forget that we are an integral part of the educational program. These basic responsibilities are the same regardless of where they are performed. If these responsibilities are to be carried out effectively in the schools we must have a distortion-free communication system.

Distortion in the form of misunderstanding is inevitable when administrators are not made aware of the diverse responsibilities of the speech, language and hearing personnel in the schools. A commonly

distorted concept, for example, involves the "personal freedom" that itinerant personnel appear to have. What appears to be "freedom" is, in reality, a more demanding type of responsibility than that of our fellow professionals in the schools. Because of our "freedom" we must present ourselves professionally through punctual and consistent maintenance of our commitment to provide clinical services to speech, language and hearing handicapped children in the schools. In doing so, we reduce the amount of distortion which in turn results in effective professional relationships.

Distortion in the communication between our profession and school administrators must be diminished at various levels of the educational structure. To achieve this goal the following recommendations are made to clinicians, supervisors (both state and local) and professional organizations:

CLINICIANS

1. The individual clinician can communicate most effectively with educators and administrators through conscientious program organization and administration. A successful program reflects adherence to a regular schedule and the maintenance of written records and reports. Positive relationships and communications with parents and other professionals in the school are objectives sought by any responsible clinician.

2. Unfavorable parental attitudes will adversely affect relationships with administrators. Positive parental attitudes will result in a more effective program. These parental attitudes, referred to as "Parent Power" during this Conference, can be developed through an on-going program of:

   a. effective therapy
   b. personal parental conferences
   c. parent information publications
   d. presentations to organizations such as P.T.A., Civic groups, etc.

SUPERVISORS

1. State Supervisors of speech, language and hearing programs are encouraged to keep all school administrators and local supervisors of speech, language and hearing programs informed of regulations, guidelines, and recent legislative action through the use of advisory committees, newsletters, and publications.

   State Supervisors should become actively involved in state-wide meetings of school administrators as a means of informing them about rationale for the:

   a. speech, language and hearing program as it relates to the total educational process
   b. innovative programs
   c. recent trends

   State Supervisors should provide liaison service to the universities preparing educational administrators to inform the university of the need for prospective administrators to understand the importance of integrating the speech, language and hearing program into the total educational program.

2. Local Supervisors of speech, language and hearing programs should make personal contacts periodically with all administrators (state and local) in their programs by means of:

   a. personal conferences
   b. regional meetings
   c. social-professional activities

   Local Supervisors should establish effective relationships with universities and colleges to encourage education of future administrators in the philosophy and objectives of speech, language and hearing programs.

   Local Supervisors should actively involve administrators in program planning and evaluation through formulation of written policy and procedures.

PROFESSIONAL ORGANIZATIONS - national, state and local.

Professional Organizations are encouraged to invite administrators to attend speech and hearing meetings and conferences.

Professional Organizations should encourage administrators to become program participants in speech and hearing meetings and conferences to provide administrators the opportunity to present their views on the integration of speech, hearing and language programs into the total educational process.

Professional Organizations should encourage members to submit articles for publication in journals which will eventually be placed in the hands of school administrators.

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